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# Termination: how families experience the end of family therapy

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Termination:

How families experience the end of family therapy

by

Henry Boone Grant, Jr.

A dissertation submitted to the graduate faculty  
in partial fulfillment of the requirements for the degree of  
DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies (Marriage and Family Therapy)

Major Professor: Harvey H. Joanning, Ph. D.

Iowa State University

Ames, Iowa

1999

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Graduate College  
Iowa State University

This is to certify that the Doctoral dissertation of  
Henry Boone Grant, Jr.  
has met the dissertation requirements of Iowa State University.

Signature was redacted for privacy.

~~Major Professor~~

Signature was redacted for privacy.

For the Major Program

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For the Graduate College

To my wife

Georgia Barnes Grant

and to our children

John Boone

James Applewhite

Adrianna Barbara

who left home, kin, friends, North Carolina cooking,

and a warm Southern climate

for this cold and windy Iowa adventure

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**ABSTRACT**

Families who experienced a successful outcome to family therapy appeared to be ready to terminate when they had made a paradigm shift in their thinking about family problems and how to resolve them. In this study families communicated two signs of readiness to terminate therapy: 1) the family stopped focusing on the child as a problem and viewed the child as growing up; 2) the parental dyad expressed a renewed sense of confidence in themselves to handle any relationship problems that might arise in the family. Families who remain focused on the problems of the child were not confident in their own ability to handle relationship problems and frequently sought an outside agent, e.g., therapist, to create and/or maintain a solution for the family, i.e., to "fix" the index person. The families who remain focused on the index person were often ambivalent about termination. Furthermore, families who showed a readiness to terminate use a three-stage process, a) the family relied on the therapist to initiate the suggestion, b) the family eventually claimed ownership of the idea, and c) the family negotiated with the therapist how to terminate therapy. A good therapeutic alliance between family and therapist did not appear to influence the decision to terminate. Ambivalence by families towards the social worker also did not appear to influence the family's readiness to stop family therapy. Three areas of further research are suggested by this study. How might therapists gauge readiness to terminate in families? Are there any early signs of readiness

to stop therapy by which to predict when to stop? What family qualities could best aid the parent in becoming confident about handling family relationships?

## **CHAPTER 1**

### **INTRODUCTION**

#### **Origin of the Research Idea**

As a family therapist in clinical practice, the researcher had often noticed that families appeared to give signs of being ready to stop family therapy before the therapist was ready to stop. Families often left cues for the therapist of their readiness to stop therapy. For example, the family might have requested that the television remain on during therapy, or the family might have “forgotten” the scheduled time for therapy, or the family might have visited socially with the therapist, etc. After numerous experiences like this, the researcher began to question clients about how they decided to stop. The researcher heard in family conversations that families tended to regard terminating therapy as their prerogative. Conversations with other therapists often confirmed this as the family’s view. Therefore, the researcher began to consider ways to discover how families might look at the experience of ending therapy. Subsequent inquiries in reading, literature searches, and in discussions with colleagues convinced the researcher that, while terminations were looked forward to in the experience of some families, the ending of therapy was seldom considered a distinct stage or experiential event by therapists. The termination of therapy appeared to be a larger construct in the mind of the family than it was for the therapist. So the researcher began to wonder, what was the ending or termination of therapy really like for family, and how might they have reached the decision to stop therapy?

### **Purpose of the Study**

The purpose of the study was to discover and understand how the family viewed the termination of family therapy using ethnographic interviews.

Ethnographic interviews resulted in a description of the phenomenological patterns of the family experience of the ending of therapy. In this research the central concept being studied was defined generally as an attempt to understand how the family perceived the decision to stop, what sort of context was involved in making the termination decision, and what meanings did the family make of the termination. The study used a qualitative method of inquiry to enable the family to express experiences and meanings in their own, everyday language. As the findings began to emerge, the researcher used the initial understandings to direct additional interviews to discover other facets of the family's experience and its meaning. The unit of analysis was the family who had participated in in-home family therapy in the state of Iowa and had already finished therapy. In-home family therapy was a form of family therapy in which the therapist visited the family rather than having the family visit the therapist in an office. The ethnographic interviews took place in the home of the family, in a similar context in which family therapy had occurred.

### **Importance of the Study**

Diverse interpretive communities should find the study helpful. The study's findings should be of most interest to family therapists. With the increasing prevalence of managed care in the mental health field, finding out how families perceived the experience of termination should be of intense interest. Increasingly managed care has promoted brief therapy as a more desirable mode of therapy

delivery, resulting in fewer sessions in general and a quicker ending. How the family views termination and how meaning is made of the termination process should help inform the new emphasis on shorter therapy. Additionally, the meaning of termination experiences should help family therapists understand how termination and the meaning of termination help or hinder the course of therapy. Additional studies based on this preliminary research might be employed to understand termination experiences as an outcome experience of therapy, as well as some form of understanding of the meaning of therapy to the family. Social constructionist family students may also find the findings important in articulating the client's point of view. Additional research in client variables might also use the findings of this study, inasmuch as most previous research on client variables have relied overly on demographic data to correlate premature termination with clients' descriptions (Garfield, 1993). A companion study done solely on family's point of view of termination might be most helpful in areas concentrated on abrupt endings in family therapy. Students of transitions and rituals in the family studies field may also find this study beneficial in understanding another transition that occurs in family settings. Just as transitions serve as significant nodal points in the individual's or the family's life (Falicov, 1988), so termination from therapy and how the transition is made meaningful to the family could accentuate critical relationships that engage families in the community. Tracking family connections beyond the nuclear family, e.g., ecomaps, may highlight transitions similar to the one a family makes when terminating therapy. How families make meaning of those kinds of transitions and



how that helps or hinders the family in other kinds of community connections may be especially useful family researchers.

Qualitative researchers in the family therapy as well as other fields should also find the study's findings beneficial. Use of the emergent design, purposive sampling, and ethnographic interview analysis are all critical components of a growing field of research aimed at helping previously marginalized portions of the population to articulate their experiences and meanings. Certainly, in the field of family therapy, the family's voice has not often been emphasized. Feminist standpoint research (Oleson, 1994), interested in stressing the everyday experiences of women and the contexts where they are silenced, also may find this study helpful in articulating the parent's voice, especially the voice of the mother. Since typically in the researcher's clinical experience the mother of the family may often be the initiator of family therapy, it might not be surprising to find that women in the family might also have been the initiators of termination. Additionally, qualitative researchers, philosophically-oriented toward post-modern advocacy of everyday language and away from abstruse languages of research and specialization (Wittgenstein, 1953) may find the results of this study helpful in focusing on plain language as the medium for understanding the family. Social constructionist researchers may also profit from research that focuses on the meaning of therapy phenomena for family members as co-equal co-creators of the therapeutic project (Boss, Dahl, & Kaplan, 1996).

## **CHAPTER 2**

### **REVIEW OF RELATED LITERATURE**

#### **Introduction**

The following review of related literature included the research, theory and clinical practice precedents for the research. "Relates" refers to similarities concerning the research but not necessarily to "sameness". No studies have been found which relate specifically to accessing the family members' experience of family therapy termination.

Psychotherapy in general and family therapy in particular traditionally has not considered the client to possess many resources and capabilities. Theorists and practitioners have viewed the therapist as the essential actor in unlocking what potential each client has. The psychotherapy leaders and teachers have required the therapist to guide the client in making "real" the unrealized potentials of the client. Without therapist aid, the practitioners and theorists believed that client potentials would remain unrealized. This view of the role of the therapist has been the prevailing view of psychotherapy since its inception with Sigmund Freud and continues today as the mainstream approach across the field (Hoffman, 1981; Nichols & Schwartz, 1984).

The field of family therapy began in the 1950s and 1960s in the United State with the idea of including families of clients in the therapy process. Some practitioners began to ask families to participate in the actual psychotherapy interview or consulted family members after the interview to keep family members up-to-date concerning the progress or deterioration of their "sick" relative's situation

(Bateson, Jackson, Haley, & Weakland, 1956; Hoffman, 1981). As clinical practice evolved, the practitioners looked at family interactions as integral to the development and maintenance of individual behavioral problems and dysfunctions (Bateson et al., 1956). The family therapy field has continued to hold dear the central idea that problem solutions remain in the control of the therapist (Hoffman, 1993). The therapist controlled the processes of therapy as well as the directions the client needed to know to proceed in the process of dealing with their problems(s). Gradually practitioners began to view the whole family also as interacting that stabilized problems within the family. This view of patterns of family interactions tended to encourage the perception of the identified person as one who “maintained” the symptoms and who served as an outlet for underlying family stresses and tensions. By addressing these patterns within the context of all family members, family therapy emerged as a distinct and unique form in the psychotherapy field (Hoffman, 1981).

## **Family Therapy**

### **Family Resources**

Family therapy was viewed as a form of psychotherapy that based itself on the concepts of family behavioral change and therapist action (Becvar & Becvar, 1993). Only a few family therapists, however, had tended to regard the family as resourceful. Milton Erickson, an original in the field of family therapy, oriented his clinical work on the notion that the clients had resources that they used effectively to manage their own problems and to achieve their own goals (Haley, 1973). Erickson suggested techniques of hypnosis to assist clients in unblocking their natural

resources to solve their own problems, then relied on a series of subsequent interviews with the client to maintain the new orientation (Rossi, 1980; Rosen, 1982). In a separate but similar vein, Virginia Satir contended that families changed their sense of self-worth, patterns of communication, and family rules by using the resources within themselves to make necessary changes towards better functioning. Satir sought to encourage in therapists a more positive outlook that could effect changes in family behavior (Satir, 1964, 1972; Satir & Baldwin, 1983). Murray Bowen, another pioneer in family therapy, produced Bowen theory out of his realization that learning how to stay calm and stay in touch with the members of one's family of origin was the key to dramatic changes in the patterns of behavior in one's own nuclear family (Bowen, 1979; Kerr & Bowen, 1988). These three originators of family therapy have had the most positive regard for the resources of family members in sorting out family problems and utilizing these resources to come up with new solutions. That said, even these "schools" of family therapy operated within the traditional stance that therapy was the purview of the therapist, and that the therapist must therefore have been in control of both the therapy session as well as the course of therapy. Other developing therapies in the field, e.g. Milan family therapy (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978; Gelcer, McCabe, & Smith-Resnick, 1990), Strategic family therapy (Haley, 1976; Giorgio & Watzlawick, 1993), Structural family therapy (Minuchin, 1974; Minuchin & Fishman, 1981), MRI or Brief family therapy (Watzlawick, Jackson & Beavin, 1967; Fisch, Weakland & Segal, 1982; ) all agreed that the therapist was the agent of activity and the client was responding to the initiatives taken by the therapist. Although the three

mentioned above sought to find the family resourceful, the gist of the interventions proposed all originated with the therapist and the family members were allotted the passive role and the responsive voice. The therapist as expert has been the dominant stance. From the vantage point of the therapist as expert,

the therapeutic process must inevitably result in the slow but inevitable replacement of the client's story with the therapist's. The client's story does not remain a free-standing reflection of truth, but rather, as questions are asked and answered, descriptions and explanations are reframed, and affirmation and doubt are disseminated by the therapist, the client's narrative is either destroyed or incorporated – but in any case replaced – by the professional account. (Gergen & Kaye, 1992, p. 169)

Social science theorists, however, influenced by feminist and postmodern perspectives, began to challenge the notion that a therapist, researcher, or any social interventionist could have taken the role of an expert “outside” the family and still have effectively influenced family members.

### **Family Voice**

The publication of Carol Gilligan's book, In a Different Voice (1982) started what became a crescendo of feminist advocacy for women's and the family's point of view and challenged to the dominant, “male,” or traditional perspective that heretofore had directed social science theory and family therapy research. Feminists actively supported giving legitimacy to the voices of women or women's opinions that had been otherwise marginalized, ignored, or minimized (Hare-

Mustin, 1978; St. George, 1994). Other feminists began to “deconstruct” the stereotypes and terms related to gender (Libow, Raskin, & Caust, 1982; Bograd, 1988). Another feminist challenge addressed the notion that the context of the family could be ignored or that the differences in power could be glossed over (Avis, 1988; Goldner, 1985). While important to realize that there was no “universal” feminist point of view and much debate existed among feminists of every hue and color (Hollinger, 1994), the major impact of feminists in social science was to bring to the fore issues of power and powerlessness in family situations and the articulation of “voices” that had been previously ignored or rendered invisible.

Under the rubric of postmodernism Kenneth Gergen (1982, 1985) suggested that knowledge was socially constructed, that there were multiple realities in any human system, and that even the self was socially constructed. Rom Harré (1986) also challenged the widely held notion that emotions were discrete, internal states, suggesting instead that emotions were socially constructed in different cultures. In the same vein, Geertz pointed to the ascendancy of “local” knowledge as the proper focus for the researcher (Geertz, 1983).

With the advocacy of marginalized voices and the advent of the new epistemology of social construction, some family therapists began to look at the relationships of therapists with family members as a process of “co-constructing” therapy (Anderson & Goolishian, 1988). The social constructionist family therapists viewed family members as equal partners in creating therapeutic conversations. The role of the therapist as expert was debunked (Anderson & Goolishian, 1992). Anderson and Goolishian stated several assumptions that have had pervasive

influence on the collaborative approach to family therapy. First, the collaborative language approach assumed that the therapeutic relationship originated in a linguistic connection. Second, meaning and understanding in the therapeutic alliance was constructed by the participants. Third, the socially constructed meanings were actively employed in organizing problems and in dissolving problems. Fourth, the therapeutic conversation was a mutual exploration, a two-way exchange. Fifth, the therapist, insofar as he or she might have been considered expert, was only an expert in facilitating conversation (Anderson & Goolishian, 1992). Out of these assumptions has emerged a new orientation of family therapy that rejected family therapy as a system and perceived families instead as "interpretive communities" (Paré, 1995; Fish, 1980). The new social constructionist epistemology has evolved into three different foci based on similar assumptions: narrative therapy (White & Epston, 1990; Freedman & Combs, 1993; Parry & Doan, 1994) stressed the stories of family members and sought to help the family "re-author" their story; solution-oriented therapy (de Shazer, 1991; O'Hanlon, 1993; Walter & Peller, 1992) emphasized the construction of solutions within the therapy session itself; and collaborative language approaches to family therapy (Anderson, 1993; Anderson & Goolishian, 1988; Goolishian & Anderson, 1992; Hoffman, 1993; Andersen, 1991, 1992) focused on therapy as a language event which the therapist led but declined to direct the family towards particular goals, outcomes or solutions. Families were encouraged to devise its own goals for change. The social constructionist family therapies gave the family its greatest voice and allowed the family to articulate goals and reasons for continuing or terminating therapy

(Wetchler, 1996). The primary researcher of this study located his clinical practice in the collaborative language approach of social constructionist family therapy.

### **Family Therapy Termination**

Termination in family therapy had been assumed in family therapy, but had seldom been viewed as a distinct phase of therapy or as an experiential event. The mainstream of family therapy, before the advent of social constructionist orientations, viewed the therapist as in control of the therapy session as well as during the entire course of family therapy. Consequently, mainstream family therapists continued to view termination as the prerogative of the therapist.

When the client left therapy before the therapist was ready, the therapists tended to regard this early departure in terms of the therapist's loss (Treacher, 1989). When a client family dropped out of therapy prior to the therapist's approval, the departure from therapy was viewed with alarm, disappointment, and frustration. Schedules were viewed as having been disrupted. Lost revenue was noted. The therapist's sense of clinical competence was demeaned (Bischoff & Sprenkle, 1993). Heath (1985) had suggested that therapists might have been better assuaged concerning sudden terminations if the therapist could have used a medical model that increased the lengths between visits and encouraged the client to return for check-ups if the problem recurred.

Most of the research that related to early disengagement had been conducted in individual psychotherapy (Garfield, 1986, 1993). The researchers reviewed by Garfield dealt primarily with demographic variables of the client. The most prevalent finding has suggested that there may have been an inverse relationship between a



client's socioeconomic status and rejection of therapy, but those findings have been inconsistent.

Only a small number of studies in the literature on dropouts have come from family therapy (Bischoff & Sprenkle, 1993). Of the studies that have been done in family therapy, most dealt with client demographic variables. Bischoff and Sprenkle stated (1993, p. 356),

socioeconomic status is the variable most often found to be related (inversely) to premature termination in family therapy. However, it is unclear whether the therapist or client is responsible for initiating these terminations.

Some researchers, for example, have found mixed results connecting Blacks dropping out more frequently than Whites (Viale-Val et al, 1984). Pekarik (1985) found that families referred for family therapy by individual professionals or who had referred themselves were more likely to continue in treatment than those referred by agencies. In addition, a client who had also been involved in another agency for additional treatment might have been more likely to discontinue treatment. Other researchers have found some evidence of correlation for drop-out variables, such as lack of satisfaction with family life prior to starting therapy (Anderson, Atilano, Bergen, Russell, & Jurich, 1985), expressed emotion (Dare, Eisler, Russell, & Szmukler, 1990), the problem viewed as residing in an individual (Allgood & Crane, 1991), symptom appearing to be of short duration (Gaines & Stedman, 1981), and failure of the therapist to meet client expectations (Calvert & Johnston, 1990). Serious questions about the design of premature termination studies also have been

raised by Bischoff and Sprenkle (1993). They cited serious definition problems, “drop-out” as a unit of analysis, inconsistent identification of the type of treatment given in the research studies, studies of drop-outs as an after-thought via another research project, and failure of a number of studies to include data about client premature termination. In their comments about future research, Bischoff and Sprenkle conclude (1993, p. 365)

It would seem helpful to include the clients in any determination of dropout status. After all, it is their therapy, not the therapist's. ...In addition to asking clients why they “dropped out” of therapy and the degree to which they believe therapy was helpful, it might also be useful to ask all clients to identify what it was about therapy that was helpful to them.... Clients potentially provide a wealth of information that is infrequently accessed.

In summary, the review of related literature verified that there was a need for research to find ways to access the family members' point of view relating to termination in family therapy. Because there has been scant research on termination in the psychotherapy field in general and even less research on termination in family therapy in particular (except relating to drop-outs), and because therapy has been heretofore conceived of as the purview of the therapist with the resulting marginalization of the family members' voice, there appeared to be a need for the research of this study. In fact, because of the dearth of research that activates the clients' voice relating to termination, this study appeared to be an original research project in an undeveloped area of the family therapy field.

## **CHAPTER 3**

### **METHODOLOGY**

#### **Assumptions And Rationale**

Given that this study was researching an area that researchers had neglected or overlooked over the course of history in the family therapy field, an exploratory, qualitative methodological approach appeared the appropriate mode of inquiry. Researchers who operate out of the qualitative or phenomenological perspective seek to understand the meaning of events, actions, and interactions in their naturally occurring contexts from the participant's perspectives (Moon, Dillon, & Sprenkle, 1990). Thus, the principles of qualitative research methodology attempt to steer the first phases of the inquiry by allowing flexibility in the design. This flexibility supports a more fluid response to the data, fluidity not always present in quantitative designs (Lincoln & Guba, 1985).

The assumptions associated with a qualitative inquiry may best be understood in contrast to a quantitative approach. At the ontological level, a quantitative approach assumes that there is an 'objective' reality 'out there' which can be accessed through appropriate, parametric and/or non-parametric methods, so that as more information is assessed the researcher begins to see a common perspective (Creswell, 1994). At its heart, the quantitative methodologist assumes that a cohesion or convergence of reality will occur as the data are gathered. By contrast, the qualitative methodologist assumes that reality is constructed by the individuals involved in the inquiry and thus does not often discover a single, 'objective reality' or convergent reality. Qualitative researchers, such as Guba

(1981) and Patton (1990), suggest that there are multiple realities involved in the subjects' experiences, so that generalities that may be inferred from the data would tend to diverge rather than converge as more information is gained.

At the epistemological level, a quantitative researcher desires that the researcher maintain a strict separation from the observed in order to conform to accepted principles of objectivity (Moon, Dillon, & Sprenkle, 1991). By contrast, the qualitative researcher wants to minimize the distance between the observer and the observed in order to obtain closer interactions between the researcher and the participant. The qualitative research trusts that closer interactions will enhance data collection processes (Creswell, 1994). A corollary of this epistemological stance is that the observer may create separation from the observed only in a limited sense (Moon et al., 1991). Whereas the quantitative methodologist is seeking to widen the separation between researcher and subject, the qualitative methodologist is seeking to use the narrowed distance for his or her own research advantage.

At the axiological or value level, the quantitative researcher seeks to create a research environment that is value-free and unbiased, while the qualitative researcher strives to accept a value-laden research environment and find ways to benefit from the biases that incur automatically in social research situations. To the quantitative researcher, the qualitative research environment appears loaded with error, which needs to be accounted for or reduced. By contrast, the qualitative researcher accepts that the error in research is inevitable because every social interaction occurs in a context-specific setting which necessarily includes the biases of the researcher (Patton, 1990).

The quantitative and qualitative researchers also differ over the rhetorical assumption. The quantitative researcher uses a more formal language, previously defined concepts of meaning, and the impersonal voice. The qualitative researcher, by contrast, welcomes informal language, embraces an evolving set of understandings about meaning, and seeks to energize the personal voice. The rhetorical assumptions are critical to the qualitative researcher because the researcher desires to utilize the personal interaction as a way to access the subject's experience and narratives during the course of data collection. The qualitative researcher wants the participants to utilize the language they are most familiar and comfortable with, and wishes to be available to the participants as they articulate their own perceptions and experiences. Thus in the qualitative approach the researcher desires to minimize the separation between the observed and the observer/interviewer. The qualitative researcher is above all seeking to understand human phenomena arising from the experience of the research informants (Joanning, Newfield, & Quinn, 1987).

The differences in assumptions between the two paradigms pinpoint how the qualitative paradigm is a useful approach for exploring complex human relationships and conversational interactions. While a quantitative approach has its own strengths especially in addressing the generalizability of results and organizing data in an elegant way, the strength of a qualitative approach is the opportunity of the researcher to change in response to changing perceptions as the study progresses. While a quantitative researcher assumes that a model is to be hypothesized prior to the beginning of a project and rarely to be changed during the project, such an

approach does not take good advantage of new information that may pop up during the course of the project (Joanning & Keoughan, 1997).

In qualitative methodology, the researcher becomes the primary tool for data collection and analysis. The flawed human serves as the instrument for data collection instead of imperfect inventories, questionnaires, or machines (Merriam, 1988). The human instrument works in conversational interaction with the participants to explicate and elucidate the process of data collection. Through impacts on the process the researcher evolves and improves his or her ability to collect data. The research process, in the qualitative paradigm, is thus a recursive process, whereby the researcher as an instrument is evolving while emergent understandings arising from research participants are also developing during the course of the conversation itself. The immersion of the researcher and the research participants in the interview context permits information to arise that otherwise might be lost with less context-sensitive methods (Lincoln & Guba, 1985).

The qualitative researcher maintains, implicit in the acknowledgement that the researcher is the primary instrument, that there must be, eo ipso, a great diversity of data collection approaches. Central, however, to qualitative data collection are participant observation (Vidich & Lyman, 1994) and the interview (Spradley, 1978). The focus of each arena of data collection is the setting. In participant observation, the setting is located in the perceptions of the researcher as he or she watches the flow of events in the lives of the participants in a particular place (Wolcott, 1992). In interviews, the setting is located in the perceptions of the interviewer as he or she participates in conversation with the participants about their appraisal of an event or

course of events in the their life. In both instances, the data collection is related to an accumulation of perceptions. Eventually, the researcher renders the perceptions into words or texts (Miles & Huberman, 1994; Wolcott, 1992) which become the arena of analysis.

### **Context of the Study**

This study was located in the tradition of phenomenology with its emphasis on description of multiple data sources, general regularities of language, interactional habits, and access of everyday-type situations based on interviews, with an underlying reference to the possibility of uncovering the beginnings of a pattern (Miles & Huberman, 1994; Erlandson et al., 1993). While there were many different types of qualitative data collections styles to be employed, in this study a variation of the ethnographic interview (Spradley, 1979) was followed. The researcher interviewed families sitting together in their own residence several months after the family had terminated therapy. The families interviewed represented a relatively homogeneous group (Patton, 1987) who had been engaged in therapy in a private family therapy clinic. The contracting agent for referring the family and for paying for the therapy was the local county department of human services. The families represented the demographics of the rural counties in the state of Iowa, that is, mostly white, with children under the age of 18, in which a child of the family had been identified as needing to regain the skills necessary to remain in the home of his or her biological parents. While conversation with these families appeared unstructured, the researcher used mini-grand tour and structural questions to guide the flow of conversation (Spradley, 1979). The interview with each family was

audiotaped and transcribed, thus providing a way to economize time and minimize costs for the study. A second contact, some by telephone and some in person, was made to check the emerging results with participant families.

### **Researcher Profiles**

#### **Primary Researcher**

The primary researcher was a 56-year-old white, married male, and father of three grown children. A doctoral student in a Human Development and Family Studies Department with a specialization in Marital and Family Therapy, the primary researcher had in excess of ten thousand hours of experience as an in-home family therapist working with clients of this population. The researcher also had been involved in another study with interviews using similar ethnographic-type, grand tour questions. Additionally the researcher had experience using audiotapes for supervision and for other research initiatives. Previously the primary researcher had undertaken an intensive study with another researcher in 1997 to learn how to refine his skills in data collection techniques and data analysis following the pattern of the ethnographic interview recommended by Spradley (1979). The experiences gained in these activities enabled the primary researcher to train the other research team members in the techniques of interview analysis. The primary researcher was the sole interviewer.

The researcher, following good ethnographic practice, recognized the importance of stating the personal assumptions prior to the beginning the ethnographic interview process. These assumptions had evolved from the researcher's clinical experience and training at Iowa State university in qualitative



research methodology. These assumptions influenced how the researcher used the 'self' as the instrument of measurement in the collection of data. The assumptions were:

- Researchers should explore an area of research before trying to confirm research findings.
- Qualitative research methodology is especially effective method for exploring the experiences of participants.
- The everyday language used by family members conveys both experiential information and meaning.
- Meaning as conveyed by family members communicates a subcultural self-understanding with its own vocabulary.
- The meaning system of family members may be apprehended by a trained interviewer who is willing to 'learn' from the family.
- Qualitative research methodology attempts to explore the nature of family meaning systems by placing the researcher in the 'student' position vis-à-vis the participants.
- The essential attitude of a 'student' is expressed in the phrase "I don't know my way about" (Wittgenstein, 1958, p. 49).
- Family members have a co-equal voice in the construction of their meaning with each other, so having more family members present for the ethnographic interview should yield greater data collection possibilities.

- Using the researcher as the primary instrument of investigation permits a flexibility and responsiveness to participants enabling more thorough data collection.

### **Assistant Researcher 1**

The assistant researcher was a thirty-four-year-old, white, married female, and mother of an infant, who had completed her Ph.D. in Human Development and Family Studies with a specialization in Marriage and Family Therapy. She had three years of clinical experience with in-home family therapy. The assistant researcher has worked together with the researcher in a previous research project to evaluate family experiences with in-home therapy. The assistant researcher and the primary researcher collaborated in that project in learning how to interview families and how to analyze the data for themes or domains of meaning. She was trained in the use of ethnographic interview techniques and analysis by courses taken at Iowa State University as well as by in-the-field experiences. The assistant researcher was employed at the time of the study as Director of Family Therapy, training students in family therapy techniques and strategies at the University of Louisiana at Monroe.

### **Assistant Researcher 2**

The second assistant researcher was a twenty-nine-year-old white, single female who was a Ph. D. candidate in Marriage and Family Therapy at University of Louisiana at Monroe at the time of the study. She was a native of Israel. The second assistant researcher had done other qualitative research analyses by hand while working in other research projects and had been trained as a marriage and family therapist through her university program.

**Assistant Researcher 3**

The third assistant researcher was a forty-one-year-old white, divorced female, mother of four grown children, who was working on a Master's degree in Marriage and Family Therapy at University of Louisiana at Monroe. She was new to qualitative research methodology and had had no training in doing qualitative research analysis until she was introduced to the analysis process by the primary researcher.

**Dependability Auditor**

The researcher's major professor served as the dependability auditor supervising all aspects of the study. The auditor was an expert in the qualitative research methodology field and had supervised numerous qualitative research projects. The auditor ensured that the researcher conformed to the usual practices required by practitioners in the qualitative research field. The auditor monitored the study in all its phases.

**Role of the Researcher**

The most critical role of the researcher in qualitative research methodology is to collect the data. To insure trustworthiness, the researcher needed to make explicit and follow conscientiously detailed and exacting methods to establish that the researcher was faithfully reproducing the experience of the participants. To this end, the researcher made explicit researcher biases that might have influenced how the data is collected. Additionally the researcher adapted himself to the varieties of experience that the participants communicated to him, and allowed himself to be flexible enough to respond to information learned during the course of the study.

This flexibility thus modified his receptiveness to the vagaries of the communication styles of participants (Creswell, 1994). The engagement of the researcher with each participant allowed the researcher to construct structural questions as well as mini-grand tour questions (Spradley, 1979) to prompt participants to remember their experiences oriented around the termination of therapy. The ability of the researcher to allow himself to be side-tracked by participants often produced additional insights from participants that would have been less likely if the researcher had been less committed to a flexible protocol. By following the traces from both the verbal and non-verbal communications, the researcher enabled the participants to dig out the meaning pertinent to their experiences (McCracken, 1988).

### **Research Team Narrative**

The research team met for the first time at a qualitative conference featuring John Creswell as the speaker at Iowa State University in March 1999. During the breaks and after the conference, the researcher and the first assistant discussed the research idea. The team reviewed the protocol that had been developed previously, and compared the overall research plan with what Creswell was suggesting in his presentation with what we were proposing to the Program of Study Committee. After the proposal was approved on March 30, 1999, the research team again reviewed the mini-grand tour questions and agreed on a tentative timetable for the research progress. Since we knew that the first assistant would not be resident in Iowa beyond April 30, 1999, we agreed that the primary researcher would be the only person to conduct the interviews. The research team would assist in debriefing

after the interviews and would help with the coding and grouping themes and domains.

Due to an automobile accident that the primary researcher had with an Iowa deer and the researcher's subsequent hospitalization, the interview timetable got pushed back to the end of the summer of 1999. After the first interview was conducted on August 9, 1999, the researcher's experiences were debriefed by the assistant researcher. The team bounced comments off each other about the effort to avoid too much "therapy" talk during the interview. The team suggested more references be made to the actual protocol questions. The interview process was reviewed. Team members again asked for more focus on the mini-grand tour questions while keeping the structural questions in reserve. The strategy in future interviews should be to ask the more specific structural questions only if they had not been addressed in the family in the interview. The team wanted the interviewer to try to keep the family conversation directed more at the research subject matter. The primary researcher explained that his "style" of joining with the family was to focus on current family therapy needs and relate them back to the past when therapy had been in the active stage. The research assistant emphasized the strategy of sticking more directly to the protocol.

The research team added two new members when the team met on September 10, 1999 in Louisiana. At this meeting, the research proposal was introduced and recruitment procedures for getting interviews with families were outlined. The qualitative software program, Atlas-ti, was introduced and reviewed. Copies were made available so each team member might have the program in their

personal computer. The direction booklet was introduced and preliminary instructions were given to each team member. The first interview transcript was introduced to each team member and a review was made of the interview process. Spradley's two semantic relationships were introduced and team members were encouraged to use the language of the family member as a guide to establishing codes. When coding uncertainties arose, each team member was asked to refer back to the two Spradley semantic relationships as a guide. Numerous examples were given for the edification of the team members. After introducing the coding process, all four team members took a portion of the first interview and coded it individually by hand. After the ten pages of the interview were coded, comparisons were made of what had been highlighted in each person's effort; then codes were compared. Emphasis was again placed on using the everyday language of the family as a guide for the initial codes and steering away from more technical, family therapist language. Two of the assistants more obviously were enamored with the more technical codes, which might have been more "thematic" groupings at a later stage of coding. Everyday language of the participants was suggested as the first preference.

The four-member team met again on September 28, 1999, by telephone conference. Three team members were located at one telephone in Louisiana, and the primary research was located in Iowa. Transcripts of the second, third, fourth, fifth, and seventh interviews had been received, but only interviews #1, #2, #3, and #4 were coded and analyzed for the meeting. The diskette containing interview #6 had been damaged in shipment and so was not coded. Arrangements were made to

bring interview #6 to the next team meeting in Chicago. At the telephone conference comparison were made of the process each team member had gone through to make the coding, then each person's codes were named to the other team members so everyone could share. Very few questions were raised about most portions of the text that did not seem to fit in. Everyone agreed that a portion of each interview related to current family needs and desires might be of some value for other research interests but did not appear pertinent to the research questions being studied in this project. Agreement was made by all team members which portions of the text appeared relevant to past therapy process and termination experiences. Team members also agreed to finish coding the transcripts they had in their possession and bring the codes and pertinent quotations to the next meeting in Chicago. Two emergent questions also arose out of the coding related to the significance of a "safety net" for families, or the promise of additional services or efforts to secure additional services, and the impact of relationships with the social worker on the experiences of termination. These two questions were added to the structural questions of the interview protocol.

A fourth meeting of the research team was conducted in Chicago at the annual meeting of American Association of Marriage and Family Therapy on October 9, 1999. The two junior members of the team were not able to meet, but sent their coding and quotations to the meeting for consideration. Preliminary themes were discussed at this meeting and several summary statements were tried, but no agreement was reached. Thematic statements were noted and referenced for future consideration. The meeting ended after several hours with considerable

frustration that all the thematic efforts seemed so fruitless. After the meeting, the primary researcher drove to his home in Iowa and on that trip made several further efforts to state the themes and to arrange the themes in a relationship to each other. Out of these efforts issued the domains of the study. Once the researcher got home, the domains were re-organized more systematically and then emailed to the assistant researcher, who agreed subsequently that they summed up quite succinctly the first seven interviews.

After the last three interviews, the primary researcher was debriefed in telephone conversations about the interviews and how the families seemed to differ from the first seven family interviews. As a result of the additional interviews, the team solidified a domain related to poor outcome and the suggestions contained in that domain.

All of the interviews were done solely by the primary researcher because the other team members were not present in Iowa to conduct the interviews. The codings were done mutually by each member of the team and shared by each with every one else. Agreement on the themes issued out of the Chicago team meeting. Subsequently determination of domains was done by the primary researcher and confirmation then was made by the assistant researcher. The team also reviewed the findings chapter and made suggestions on how to make the findings in each domain more understandable to the general reader. Of the two emergent questions, "safety net" and social worker relationships, the lack of response by families appeared to suggest that the questions were of more concern to the research team members than they were to participant families. The research team eventually



accepted that the emergent questions might more appropriately have related to additional research concerns but apparently not to termination experiences.

## **Participants**

### **Participant Selection Criteria**

Families were chosen from a very limited range of therapy participants. Each family had received therapy and counseling services through a private agency that had a contract to provide services to families referred by a local county Department of Human Services. The agency, West Iowa Family Services, Inc., (WIFS) was contracted through the Iowa State Department of Human Services for purchase of services to provide therapy and counseling, skill development, and psychosocial evaluations to any county in the state of Iowa. Geographically, the WIFS agency limited its service to families in the western third of Iowa.

The county Department of Human Services provided free services to families whom the social workers and supervisors thought might have been in danger of having a child taken out of the home. Consequently, the focus of services always centered on a child (index person) in the family under the age of eighteen. The services were free in the sense that the family received services without monetary cost to the family.

A county social worker submitted a plan for Rehabilitative Treatment Services to the authorizing entity, Iowa Foundation for Medical Care. The plan of services focused on the danger that the index person might be taken out of the home because of the continuing problems. Two types of dangers were highlighted. First, the index person might have developed appropriately, but, because of a problem,

may have lost the developmental gains. In the first concern, the focus of therapy would be to help the child regain what had been lost. Second, the index person may have had some interactional conflicts in the home or in the community which may have become such an issue that the child might not be able remain in the home. In the second focus, the emphasis of services was to assist the child regain skills and attitudes that would positively impact the child and enable him or her to stay home. The general focus of the local county Department of Human Services social workers in either case was to prevent out-of-home placement.

After application was made by the county social work to the Iowa Foundation for Medical Care, the authorization by supervisory agency specified so many hours of therapy and counseling for the benefit of the index person. Upon authorization, the social worker contacted an approved therapy agency, such as to apply the services. The services were paid for by a combination of Iowa state funds and United States federal funds.

The contract usually offered to WIFS lasted for three to six months. WIFS could have renewed the contract if the index person's problems had not been resolved by the initial end of the contract. If new problems had arisen during the course of therapy that had been unforeseen at the beginning, then WIFS could also have been authorized to meet those and the contract extended. In some instances, the social worker denied the extension of services, depending on the reports of progress or lack of progress in therapy. In other instances, services might have been terminated because the local county had run out of money, although this has

happened only rarely. The decision to terminate by the social work has occurred only occasionally without the consent of the family or therapist.

WIFS agency therapists provided an initial treatment plan to the family and to the social worker after one month of services. The treatment plan addressed quite openly the needs and concerns of the child and the family. The treatment plans were arrived at collaboratively, with concerns included from every one who might have had a stake in the outcome, including the index person, family members, the therapist, the social worker, school teachers, law enforcement officer, court counselors, etc. All treatment goals and progress statements were phrased in language that focused on the index person. Any behavioral or attitudinal changes observed in the family were also articulated in language that reflected the advantage or disadvantage it might have had for the index person. After the initial treatment plan, the therapist submitted quarterly progress reports.

The model on which all reports and plans were based was in every instance based on deficits perceived in the index person. Reports chronicled the efforts of the index person and his or her family to overcome those deficits. WIFS therapists generally conceived of their work in terms of family strengths, family possibilities, family narratives, re-writing family stories, and the dissolution of areas where the family might have seemed stuck. Always in the background, however, stood the deficit or medical model with its focus on the index person's failures.

### **Participant Recruitment**

The researcher selected ten participant families by purposive sampling from the "Discharged Cases" of the West-Iowa Family Services, Inc. of Denison, Iowa.

Five therapists from WIFS were contacted as a group and the purposes of the study were explained to the group. Progress reports at staff meetings also helped keep the therapists up-to-date on the course of the interviews. Emphasis was placed by the researcher on selecting families whom the therapists thought might be receptive to having someone come into the home to interview the family about their therapy experiences. Ten families were suggested by the therapists initially. Of those ten, two families indicated they were not interested. A third family indicated they were still receiving therapy, although from another agency. A fourth family had moved and had not been located by the therapist. A fifth family indicated their willingness to participate but obstacles materialized that postponed the scheduled interview several times. A sixth family proved difficult to contact by telephone, but eventually, after a torturous sequence of telephone calls, that family was interviewed. When four of the families had been interviewed, the researcher requested from the therapists more names, with the possibility that some of these families might have expressed some dissatisfaction with the outcome of therapy. The second tier of recommendations consisted of twelve families, of whom four families agreed to be interviewed. Of the other eight, three of the families had no telephone and did not respond to letters, two had moved and left no forwarding address, one did not respond to any messages left on the answering machine, one had had the daughter placed in foster care and did not want to reveal that address, and one family had been acquainted with the researcher through therapy. Altogether, ten families agreed to be interviewed of the twenty-two contacted.

The rationale for a relatively small homogeneous grouping or small sample N was based on the intention of gaining information-rich participation in an in-depth study (Patton, 1990). The researcher sought to gain a vivid, exploratory description of the experiences of those families who had terminated therapy. Because the amount of information was quite 'thick' (Geertz, 1978), saturation was reached rather quickly after seven interviews. Three families were then selected purposively to access perceptions and experiences of families who had expressed some dissatisfaction to their therapist about the outcome of therapy. Although the researcher had hoped to secure a negative case, a case that contradicted the typical termination process (Lincoln & Guba, 1985), no obvious example was available for interviewing, so three families were interviewed who had a more negative view of the outcome therapy than the first seven families interviewed.

The researcher selected the first cases following the "typical case sampling" technique recommended by Patton (1990). In selecting typical cases, the researcher interviewed families who had terminated without any unusual circumstances. The strategy used to guide the recruitment was "opportunistic" (Patton, 1990), i.e., families were recruited who were willing to be interviewed. After seven families had been interviewed, the researcher sought to interview three more families who had not done well in therapy. Again, however, those recruited were selected if they were willing to be interviewed. After the initial sampling and as the findings began to emerge, the researcher then purposively selected cases of termination that appeared different or more problematic, at least in the minds of the WIFS staff consulted. The focus of the later stage of sampling sought to confirm

what patterns had already been observed in the earlier interviews, but from a different stance regarding the family's point of view about the outcome of therapy.

### **Participant Profile**

Participants were families who had terminated therapy and agreed to be interviewed. Ten families were interviewed. A more complete narrative may be found in vignettes of the families (Appendix 5). What follows is a brief summary about those families who participated in the interviews.

The smallest families were three families of three persons each, one a mother, son, and paramour, and the other two a mother with two children. The largest family was a family of a family of twenty, two biological parents and eighteen children ranging from ages twenty-three to age one. The average size of family was 6.1 persons. Six of the families had been previously divorced. Of these six, four were remarried and would be characterized as blended families. In four of the families, the biological parents remained married to each other. The ten families interviewed experienced therapy for an average of 11.4 months. The families had terminated therapy within the last six months, so therapy was a fresh experience for them at the time they were interviewed. Seven of the families communicated that they attended a church regularly and three of the families indicated they had no religious affiliation.

Seven biological fathers averaged in age 42.8 years old. All the seven were employed in jobs outside the home at the time of the interviews. Their job titles included Assistant Manager, Restaurant Cook, Factory Shift Supervisor, Independent Contractor, Carpenter, Banker and Computer Technician. Seven

biological mothers were an average age of 38.4 years. Two of these mothers worked only in the home and five were employed outside the home. Their jobs included three who worked in a factory, a public accountant firm, and a schoolteacher. The four stepparents averaged in age at 33.75 years old. One of the stepparents worked in the home and the other three were employed as a manager, in a retail store and in social service department. All the fathers described their employment by giving a job title and the mothers generally described their employment by naming the place of employment. Because two families had received and completed therapy for two children in the home, twelve children were identified as index persons. Their average age was 14.5 years old. Nine of the twelve index persons were boys and three were girls. At the time of the interviews, nine of the twelve index persons were employed in part-time jobs.

### **Procedure**

- Initial families were selected after consultation with previous therapists employed by WIFS.
- Families were contacted by telephone to introduce the research topic and to ask permission to seek an interview.
- Families who agreed were sent a mailing with a letter of information [Appendix 2] and a blank copy of the Informed Consent document [Appendix 3].
- Families were again contacted by telephone and, for those who agreed, an interview was scheduled.
- Interviews were conducted in the home of the family, and were audiotaped.

- Participants read the research introduction and signed the informed consent forms.
- The “mini-grand tour” protocol was followed in the interviews.
- At the conclusion of the interview, each family member was thanked for his or her participation and permission was requested to visit or to contact the family by telephone to check the accuracy of findings (“member checks”).
- The interviewer made notes of observations and impressions of each family member following each interview.
- The audiotapes were transcribed by a person experienced in transcriptions at a high cost to the researcher.
- Interview transcriptions were correlated with the field notes the interviewer had taken following each taping session.
- The research team did a preliminary reading of first transcripts.
- Research team did a Domain Analysis (Spradley, 1979) of the first transcripts, and coded highlighted segments of the transcripts
- The primary researcher contacted one participant family (F1) to elicit their reactions to the initial codes.
- Based on the emerging responses, the research team amended the interview protocol twice to account for findings that seemed to have concerned some of the initial families, adding a question about the “safety net” for families and adding a question about experiences the family may have had with the social worker.



- The primary researcher contacted another family (F8) by a visit in the home to elicit responses regarding emergent findings of the coding and the preliminary domain analyses.
- The research team completed a list of commonalties (codes) and uniquenesses (memos), and articulated the themes extracted from the data.
- The research team members reviewed the preliminary domain statements each had made [Appendix 4C] and agreed that they were seeing the same things although had labeled them differently.
- The primary researcher wrote a comprehensive narrative of the total analysis process and a discussion of the findings.
- The primary researcher reviewed the comprehensive narratives with the first research assistant to assess clarity of findings and comprehensibility of expression.

### **Mini-Grand Tour Questions**

In an exploratory inquiry such as this one, the researcher wanted to provide questions that would tend to be discovery-oriented. The researcher sought to pose holistic generalities in order to prevent guiding participants into specific answers. Furthermore, the researcher expected to amend or change the interview protocol as the data collection proceeded to account for what the researcher had already “learned” from the first participants. “Mini-grand tour” questions as proposed by Spradley (1979) served well as open-ended questions to access the family’s experiences of therapy and to assess the termination process. The researcher modified the “grand tour” concept to create more circumscribed queries that might

more properly be called mini-grand tour questions. While Spradley had invented grand tour questions as a way to introduce probes that sought to generate a broad range of cultural understandings, in this study the probes sought to explore more limited features of the family culture (Joanning, Newfield, & Quinn, 1987). For instance, while grand tour questions might be used to introduce an explorer to various wings of a building, mini-grand tour questions would be employed to introduce the explorer to the various rooms or spaces within one wing of the building. Thus, the mini-grand tour questions included in this research probed the scope and purpose of therapy, the general feeling about how therapy had gone for the family, how therapy had come up as a choice for this family, what changed for the family, and how therapy was concluded. Questions asked later in the interview, structured questions, related more specifically to particular processes and experiences. The interview protocol included these two types of questions, plus the questions added during the course of therapy by the research team based on early analyses. The amended questions are found in Table 1.

### **Structural Questions**

As data collection proceeded, the research interviewer began to increasingly utilize structural questions (Spradley, 1979) in addition to the mini- grand tour questions. In the interview protocol structural questions were employed in each interview to stress particular experiences of stopping, e.g., influences on the decision to stop, how family felt not having a therapist in their life, relationships with the social service system, the therapist and social worker as related to termination, and advice the family might have had for others on how to stop therapy. The researcher moreover

**TABLE 1: Mini-Grand Tour and Structural Questions**


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**Mini-Grand Tour Questions**

1. What was the experience of therapy like for this family?
2. What was the experience of ending therapy like for this family?
3. How did therapy start for you?
4. What sorts of changes did this family experience during the course of family therapy?
5. What was your experience of ending therapy?

**Structural Questions**

1. What factors influenced you most in your decision to end therapy?
  2. What person or persons influenced you most in your decision to end therapy?
  3. How did this family decide to end therapy?
  4. How did the therapist handle your decision to end therapy?
  5. Now that therapy is over for your family, do you have second thoughts or things you wish had been different for your family about how therapy ended?
  6. If you had the opportunity to advise other families about how or when to end therapy, what would you tell them?
  7. What influence, if any, did the idea of a safety net or having additional services have on your decision to stop?
  8. What were your experiences of the social service system and/or the social worker, and how might those experiences have influenced you when you decided to stop therapy?
  9. If you had the opportunity to advise other therapists about how or when to end therapy, what would you tell them?
  10. Overall, therapy would have been better for this family if ....
  11. What is your experience of being interviewed about how therapy ended for your family?
-

used structural questions to help 'structure' succeeding interviews by probing what had emerged from the initial interviews, emphasizing relational connections from early interviews. Based on the early domain analysis, structural questions served, indirectly, as an informal member check, correlating what later families had to say about their experiences with the experiences of earlier families. The interviewer also posed structural questions to suggest to later families how the family might frame or redefine their own experiences of termination. The researcher added structural questions to the conversations between the family members themselves, seeking to further extend a phrase or term that one family member had used to describe a personal experience. The interviewer likewise encouraged family or 'folk' metaphors to characterize family experiences.

The important principle at work in the use of structural questions is a sense of being tentative or suggestive in asking the question. The purpose of the structural questions was not to seek confirmation, but to prompt further reflection about the experiences of the participant and to help the researcher unpack the meaning that has started to present itself through the domain analysis. Later interviews yielded information that not only enhanced early domains but also helped expand the researcher's general sense of what turned out to be the critical domains in the research. Structural questions thus served the researcher in two important ways, adding more detailed data about the area of research, and pushing the researcher towards more general statements of analysis.

### **Data Coding**

The problem with most qualitative research is the abundance of information and how to develop order out of what can be an overwhelming mass of narrative data (Tesch, 1990). The research team used a modification of Spradley's (1979) Developmental Research Sequence in conjunction with a qualitative data analysis management software program. Atlas.ti, (Muhr, 1997) to classify and identify commonalities and uniquenesses in the data. The research team modified Spradley's (1979) domain analysis primarily by eliminating most of the semantic relationships by which the interviewer might have connected cover terms with inclusive terms. The researcher retained only the relationships of function and attribution. The function relationship posited that "X is used for Y" and the attribution relationship stated that "X is an attribute (characteristic) of Y" (Spradley, 1979, p. 111). While the other semantic relationships might have been useful to a researcher exploring a culture or subculture, these two semantic relationships seemed the most fundamental and easiest to understand and use in a domain analysis relating to experiences in therapy. The functional semantic relationship expressed a verbal connection, while the attributive semantic relationship expressed an adjectival or predicate nominative connection. Based on the semantic relationships of portions of the transcript, a code was assigned to the highlighted portion of the conversation. The research team focused the semantic relationships of the domain analyses into emergent commonalities and uniquenesses (Tesch, 1990). In Atlas-ti, portions of the text that seemed to be addressing similar foci were given codes. Portions of the text that seemed to be unique, without obvious connection to other selected text, we

labeled memos and descriptive comments were often attached to explain why this portion had been chosen. Some highlighted conversation included more than one code. The coded transcripts were then reviewed as a totality after each interview had been analyzed. Subsequently, each group of coded statements that were analyzed by each team member were compared to ascertain if the team was seeing the same things or whether there was a wide disparity of viewpoints. The research team's use of member checks with participants, the transcripts, the field notes, and research team consultations helped determine the critical nodes of meaning converging around the commonalities of the data. New and confirmed semantic relationships from the analysis of transcripts of later interviews were added to initial domain analyses, emergent commonalities, and fledgling statements of meaning. The three negative case interviews enhanced the unique qualities of the domains. After the last interview was analyzed, a list of domains was finalized and rewritten to reflect the primary researcher's gestalt of the findings. The codes and memos were then reviewed to see how well the domains reflected the family remarks in the transcripts. A copy of the domains was reviewed by the research assistant to ascertain clarity of thought and how well the domains reflected what families seemed to be saying.

### **Trustworthiness**

The researcher endeavored to establish trustworthiness in this study through recursive methods of data collection, data analysis, and triangulation. For the research to be trustworthy, the researcher sought to provide "truth value through credibility, applicability through transferability, consistency through dependability,

and neutrality through conformability" (Erlandson, Harris, Skipper, & Allen, 1993, p. 132).

### **Credibility**

Credibility is the term in qualitative methodology that refers to the "compatibility of the constructed realities that exist in the minds of the inquiry's respondents with those that are attributed to them" (Erlandson et al., 1993, p. 30). The researcher's intent was to check with the participants at least three times during the process of interviewing, twice during the early analysis and more comprehensively at the end to confirm what the researcher was finding. Each check was with a different family (F1, F8, and F1-10). Furthermore, the interviews were audiotaped, so that the researcher's perceptions of the interview could be checked with what was recorded. Additionally the research team members provided a check on the primary researcher's interpretations of what had been observed in the interviews. Use of peer debriefing with staff members of WIFS allowed the researcher to express his perceptions of each family and to check to see how consistent his experience was with what the therapists had experienced, thereby testing the researcher's initial thinking (Patton, 1990). Debriefing with research team members also helped the researcher re-think the initial hypotheses of what the participants might have been saying in the interview (Lincoln & Guba, 1985). Finally, the researcher solicited additional credibility of the findings by selecting three quasi-negative cases for inclusion in the sample (Lincoln & Guba, 1985). In the negative case analyses, the researcher demonstrated that even in contrasted cases, the fundamental assumptions of the findings still held true, thereby increasing the

likelihood that the findings of the study would be congruent with the experiences and perceptions of all the participants. Furthermore, as Patton (1990) suggested, credibility was increased when the researcher of the study considered other plausible explanations other than the one found to be most reasonable.

### **Dependability**

The researcher sought dependability of findings by establishing consistency of the data. The critical notion underlying dependability was to show that things been done with reasonable care (Miles & Huberman, 1994). Consistency of data included the idea of external reliability, that the data measures what it says it measures, as well as what some qualitative methodologists have called “trackable variance” (Erlandson et al., 1993). Trackable variance, a record of the particular sources of errors, reality, shifts, insights, emergent decisions of what the data may have indicated, as well as reformulations of the various generalizations of the study, was recorded by the researcher in research team meetings [Appendix 4a-c] as well as in a diary of the study. These two records were the foundational documents for the audit trail that documented each step in the study’s progress. The audit trail showed that what the researchers and participants had said was persistently the same over time (Patton, 1990). Additionally, triangulation through multiple data sources and using four researchers served to establish the dependability of the data findings. Finally, the researcher used a dependability auditor, a person well versed in qualitative methodology, to gauge the methods and conclusions to insure that good procedures were maintained.



### **Transferability**

This aspect of trustworthiness sought to establish how the findings of this study might apply to other contexts or to other participants (Lincoln & Guba, 1985). The critical emphasis was to decide what sort of “understanding” (Miles & Huberman, 1994) was being described as a result of the interviews. Since understanding is often inherent in the context of the family, this study tried to provide a “thick description” (Geertz, 1983) of the context for deciding how to end therapy. Both content and process were fully described, so that future readers would be able to judge for themselves how well the findings may be used for other purposes. Transferability was also sought using purposive sampling to expand the range of what participants might have experienced when ending therapy. Finally, transferability was also sought by discussing fully the limitations of the sample, the context, and the generalizations inferred from the data (LeCompte & Preissle, 1993).

### **Confirmability**

Confirmability was the element of trustworthiness whereby the researcher tried to ensure that all the data could be tracked to their original sources and that the logic used to make the interpretations was explicitly stated as part of the process of the research (Guba & Lincoln, 1989). The researcher attempted to achieve confirmability by using methods of triangulation in gathering and analyzing data. Multiple research analysts and frequent member checks served to anchor the emerging perceptions of the researcher in the family's experiences. Aberrant viewpoints were noted and accounted for when the commonalties were gathered together into domains of meaning. A recursive process of including or discounting

uniquenesses continued to be employed as the conclusions were prioritized into domains of meaning and the results were explored in the discussion. Furthermore, the researcher maintained in detail an audit trail from which the logic of the process might be inferred. Finally, the auditor examined the finished document in its entirety to verify that the methods and interpretations were consistent with the data (Brotherson, 1990).

### **Limitations of the Study**

The exploratory nature of this study necessarily limited its scope. A very few selected participants were chosen: persons who received free in-home therapy in western Iowa from an agency contracted by the Iowa Department of Human Services to provide in-home therapy for families with a child who had been identified as a problem. Similar findings have been suggested in previous studies that looked at families who had paid for therapy (Kuehl, Newfield & Joanning, 1990). An ancillary limitation is the initial focus on the child as the index person. In this sample, the focus on the child authorized government provision of therapy services. In other families, where the focus may be on a physical or mental condition, on an adult problem, or on a marital relationship, the findings of this study might not be very helpful.

Another limitation of this study related to the homogeneity of the population. Almost all families in this sample were white, so how well these findings might apply to a more ethnically or racially diverse population is unclear. Furthermore, all of the families in this study lived in rural areas or in small towns located in rural areas. No families were studied from a metropolitan or suburban

neighborhood and so the transferability of these findings to those elements of the population would be obviously restrained. Moreover, while all families received free therapy services, most of these families worked and owned their own homes and so represented a population much more self-sufficient and up-scale than might be ordinarily encountered in a program that provides free therapy. This sample also underrepresented families headed by a single parent, so transferability to those families headed by a single parent would be restricted.

A further limitation for this study related to the timing of the interviews. Most families were interviewed at least six months after the termination of therapy. Consequently, the family's recollection may have been impoverished or highly skewed by the intervening time. Similarly, no families had been interviewed about their presenting problems at the beginning of therapy, so it is hard to ascertain how well a positive outcome was related to actual events in therapy or to the memories the family had of therapy. The families presented their stories as recollections of actual events, but there was no collaborating information to support that these memories were actual events or merely ex post facto inventions.

Likewise, families with positive outcome may have already been families who tended to see the family relationally. The breakthrough redefinition may not have been a breakthrough at all, but another instance of a predilection that family already had. In essence, the family with that relational tendency would have been using a strategy that they normally employed to extricate themselves from family predicaments. In this scenario, the family needed family therapy help to activate their habitual strategy for solving problems.

Another important limitation related to the use of the researcher as the data-gathering instrument. While obviously a strength in qualitative research methodology, the human factor has inherent limitations (Patton, 1990). The researcher tried to address some of the limitations by articulating personal biases and assumptions, but bias naturally escapes the awareness of the participant observer in the very act of observation (Angera, 1997). Likewise, the researcher sought to triangulate the sources of data as well as the analyses in order to limit the researcher's proclivity for seeing what he wants to see.

A further limitation concerned the sacrifice of breadth for depth in qualitative methodology. The project was obviously an exploratory one. The researcher sought to obtain a rich description from just a few respondents, which inherently sacrificed the "landscape" of the field being studied (McCracken, 1988). Consequently the sample could not be representative of most families who engage in therapy.

A question also should be raised related to the strategy used to select respondents. The families interviewed were chosen from a list of recommendations by therapists. The therapists named families he or she thought might be open to an interview with a stranger. The families were told before their consent was obtained how they were selected for the interview, and the therapist's name was mentioned. Families thus selected may have wanted to represent the therapist well and so may have tended to over-report the positive outcomes in their family.

## **CHAPTER 4**

### **RESULTS**

#### **Introduction**

Interviews were conducted with ten families in their homes. The first seven families were interviewed in August 1999. After the seventh interview was analyzed, the primary researcher felt that saturation of the data had been reached, but since the proposal had stipulated at least ten interviews, three more families were chosen. The last three families were selected because they had not been happy about the results of therapy when it had stopped. These three families were interviewed in October 1999. Of the three problematic families, two turned out to have had two children in therapy at separate times. In both instances, the older child had had a positive result and the younger child had had a poor result from therapy. Consequently, for the population studied, eight families were interviewed who indicated they had had good or positive results for the index person as a consequence of therapy: families #1, 2, 3, 4, 5, 6, 8, and 9. All but one of these families reported that they were convinced that the changes occurred directly because of the therapy. The lone exception, family #5, indicated that changes had occurred, but attributed them more to the use of medication by the index person than from therapy. Family # 5 also indicated that the index person would not have started the medication if it had not been for therapy, but the impact of therapy had seemed to them to be more significant for the parents than for the index person.

Four families indicated that they had had poor or ephemeral results for the index person as a consequence of therapy: families #7, 8, 9, and 10. Two of these

families indicated that they had observed some changes in the index person, but they had predicted that the changes would not last beyond termination of therapy, and when therapy ended their prediction had been accurate. Of the four families with poor results, three indicated that in the six months or more since therapy stopped the index person had made significant changes like what they had hoped would happen in therapy, but they did not think the new current changes were related to therapy. One family, # 9, indicated that the family had remained in crisis since therapy ended and that a long stream of successive therapists had not helped the index person. In family #10, although both parents viewed the results as poor, the father tended to regard therapy as generative of a “paradigm change” for the family while the mother tended to regard therapy as a complete waste of time. Other than family #10, adults in the family tended to agree with each other in their assessments of the value of therapy for the family and for the index person.

The analysis process, based on the collaborative efforts of all research team members and periodic team consultations [Appendix 4], utilized the Atlas-ti© computer program to facilitate data analysis. The team analysis yielded a set of domains of meaning based on the ten interviews and notes taken by the researcher at the conclusion of each interview (Appendix 8). As the initial research findings began to emerge, the team posed two additional questions in the interview protocol, based on what the earlier interviews seemed to suggest, 1) did the idea of a ‘safety net’ or promise of additional services or additional therapy affect the decision to terminate? and 2) what were the family’s experiences of the social worker and how might those experiences have influenced the decision to terminate? (Table 1,

Structural Questions # 7 and #8) Subsequent data analysis and the later interviews eliminated the first question as a domain, but the social worker question did yield an area of concern relating to termination. The final assessments and data evaluation were formulated into domains of meaning and may be found in abbreviated form in Table 2. A more detailed description of the domains follows.

### **Domain 1: Family's View of the Index Person as the Problem**

Families in this population saw the problem that draws the family to therapy as being focused on the index person. The index person was a child under the age of 18 who may have been at risk of being taken out of the home because of some developmental loss he had encountered. While the problem a child may pose to the family might easily have been considered developmentally appropriate, for these families the index person was regarded as having problems or of being a problem. To these families, the index person seemed out of control as expressed in bad behaviors at home, poor interactional skills, school difficulties, legal entanglements, medical diagnoses, or poor parenting. The offensive behaviors observed at home included temper tantrums (F4, F5, F7, F8, F9), with unpredictable confrontations that could created uncertainty in others, (F1, F5, F7, F8). Asked how the index person confronted others, Family #1 said that the index person found it "a lot more entertaining to get up and get other people going than to get up and just take care of yourself". Family #5 said, "He likes to start something, hit 'em or push 'em or something". "Then he just bangs things around. He'll let his frustrations out".(F5) Family # 8 reported, "Well basically, confrontations on anything, if he was told to do

**TABLE 2: Domains of Analysis**

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Domain 1: Family's View of the Index Person as the Problem

Domain 2: Family's Experiences of Therapy Outcome as Good or Positive

a. Changes in the Index Person

b. Parental Changes

Domain 3: Family's Experiences of Therapy Outcome as Poor or Ephemeral

Domain 4: Process of Termination for the Family

a. Positive outcome: A proactive process

b. Poor outcome: A passive response

c. Index Person

d. Re-entry into Therapy

Domain 5: Family's View of Therapist as Related to Termination

Domain 6: Family's View of the Social Worker as Related to Termination

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anything, then he would do the opposite, very confrontational". Family #9 remarked in response to a question about a list of good behaviors, "We had a new different list of rules, we put it on the fridge and at the end of like two or three weeks that would be so crumpled up, 'cause she had ripped it up so many times and we had to tape it, you know what I mean, because she'd be like 'fuck this list' and then she'd be out the door, getting in somebody's care, so the list never made any difference." "She would beat me up all the time, physically". (F9) Others exhibited a "bad" attitude that included walking away, defying, or ignoring the parent by staying in the room (F3, F4, F5, F7, F8, F9, F10). Asked how the index person defied them, Family #3 said the index person would "walk away and mutter under his breath. He didn't want to listen to nobody, that was one of our biggest conflicts. When he first came out he was, excuse my French, an asshole." "A lotta times I just leave the house, I just go ride my bike about town". (F8) Family #4 commented, "she'd always go in and slam her door". Family #8 said the biggest defiance was "the belligerent attitude, sneaking out of the windows at night, drinking, and coming home drunk". Family #10 said, "He just stayed in bed, refused to get up, no matter what we said". "In his behavior, he defied ... the adults in his life. 'No' did mean anything and he pretty much did what he wanted when he wanted no matter what you said". (F7) Several stirred up trouble with siblings or fought with others (F1, F5, F7). Family #1 indicated they were concerned that the "little brothers would learn a lot of bad stuff" from the index person. "He likes to start something, hit or push them". "He hits me for nothing". (F1) Family #7, at a family meeting focused on the behavior of the index person, reported, "We talked about this one day with all the kids including the

index person at the table. And they each got to tell him exactly how they felt and there's not one of them that didn't say that they didn't fear him". One stepmother commented, "He's got a big heart, but if he doesn't get his way then his heart falls to his fists" (F7).

A few index persons had poor interactional skills, which got them in trouble at home and elsewhere. Some had few or no friends (F1, F3), or got into trouble with the wrong friends away from home (F1, F8). "I thought I was invincible for the longest time," one index person said, explaining the lack of trust by peers (F3). Asked how index person's behavior with friends had changed, the parents (F1) remarked, "Now he's never at home, but he doesn't get in trouble. We hear nothing from any parents that he's causing any problems like we used to". Some families found themselves screaming at each other (F4, F5); "it used to last on and on and on, hours and days (F4). " Our extent to talking was in real loud tones all the time", it went both ways, neither of us listened real well" (F6). By comparison, some would refuse to talk at all (F1, F5, F8, F10). One father commented of his son, "If he doesn't want to talk...then he clams up and gets this goofy attitude" (F5). Reflecting on the changes that had taken place, one mother (F8) said, "With both kids I have been able sometimes to use humor or whatever to talk, to talk more".

One area of trouble outside the family was school. Some children had poor grades or did not do their school work well (F1, F3, F4). Reflecting that now the index person was no longer getting into trouble with peers, a parent (F1) sighed, "But if he could do the same things with his homework and his school work". "The school wanted to put him back the first year". (F3) "She was getting D's and F's".

(F4) Some behaved poorly at school, so the school advocated putting them on medication (F5) or increasing their medication (F3). Some children seemed to have attention problems that tended to activate school concern. (F5, F8, F9) Defining attention deficit for his son, a dad said, "If it's not overly interesting to you like fishing or something like that, or Nintendo or a computer game, then you lose it". "Everyone in this family has ADHD, so we all take something, you know what I mean, before we go to school". (F9) Others might have had additional mental health problems that affected their school attendance or performance (F10, F9, F8, F3). "He was depressed, on one thing". (F10) "I wasn't social. I wouldn't go to school. I wouldn't basically even go out of my room". (F10) One child who had been taken off his medication was protected from the school by his father's intervention: "The school wanted him put back on the [medication] and I refused to have him put back on it cause we could see him slowly calming down. I said, no, we have to deal with the problem instead of prolonging the problem" (F3).

Legal complications involved some families. One index person was removed from the home because of physical abuse (F2). The father in the family tried to evade his legal responsibility. Therapy was started with this family to prevent future abuse and to restore the child to the home. Two index persons were in therapy because of being on probation (F6, F10). One was taken out of the home for being truant and therapy was started to prevent the truancy from happening again (F10). The other index person actually committed numerous crimes; e.g., broke into a gas station, vandalized school buses, shot the street lights out, broke into the community building, but somehow managed to stay in the home (F6). Other families had an

index person who ran away at night (F1, F8), drove without a license (F8), drank alcohol or smoked while underage (F8, F9) but escaped being charged. One index person was arrested for beating up her mother (F9) but charges were later dropped.

Some index persons exhibited problems that reflected serious mental health worry. Several had been diagnosed with Attention Deficit Hyperactive Disorder (ADHD) (F1, F5, F9). Others showed signs of having a learning disability (F3, F8). Three index persons took medication to control anxiety problems (F1, F3, F10). Asked to describe the medication, one parent (F3) said, "He was on 'hyper' medication." "He went into a shell".(F10) Asked what sorts of situations made him anxious, one index person replied, "Going places, seeing new people".(F3) One index person showed definite signs of Post-Traumatic Stress Disorder (PTSD) originating from an act of gang violence and death threats against his life (F10). In response to a question about witnessing gang activity, the parent remarked, "He saw someone pull out a gun and put it to someone's head and their stomach, and then threatened to kill everybody who might have told or who would have told, and he was fourteen at the time". Several may also have been suffering from various kinds of depression (F1, F2, F4, F8, F9, F10). "Concerning temperament, where [his brother] is generally a pretty happy kid, he never was". (F1) "I sorta got stuck in some, just, in depression". (F10) "He just sorta went off the deep end".(F2) While some index persons had a particular diagnosis, all those who had undiagnosed conditions may have needed therapy to help cope with their mental health anxieties which may also have affected their relationships in the community as well as at home.

Several families pointed to bad parenting as the reason for starting therapy with the index person. Some suggested the lack of structure in the home as a cause of problems in the index person (F3, F4, F8, F9). "His mother taught him a lot of wrong things", a father said about his son's need for more guidance in everyday life(F3) "It was summer months, no school, and we needed some structure for him because obviously we both work," a parent gave as a reason for starting therapy.(F8) Others emphasized unstable home situations (F3, F4, F7). One parent, commenting on where his ex-wife lived, said, "She's in a motel room right now. And she's a fly by night. I don't know, she's here, she's there, she's everywhere" (F3). "I spent three years with mom by myself. That was hell.... She's always moving. We went to eight schools in less than six month," said one daughter, explaining why she came to Iowa to live with her father.(F4) Two families suggested that the children needed therapy because their fathers had abandoned them and wanted nothing to do with them (F6, F9). "He [the father] don't want to have nothing to do with them".(F9) "So the disappointment [with his dad] there, I think, had quite a bit to do with some of the trouble he got into".(F6) One mother suggested that the family needed therapy because the father came home and expected family to act like employees. "His pace at work overflows here at home, and he has so much to do at work and a certain amount of time, and then he expects things to go just like that here at home".(F8). Another mother suggested that her son got into therapy because there was too much focus on his sister and he felt left out (F9). "We were having so many problems with [index person], that [the brother] felt like he wasn't included".(F9) Another parent said his son had been

“taught a lot of wrong things by his mother” and now he had a lot of work to undo the old habits before he could get on with the new ones (F3). In addition, one couple suggested that they had become inconsistent because they thought, “maybe times had changed where what we were doing probably wasn’t right any more” (F4). A parent commented that she had gotten so focused on control that she found she did not trust her son anymore, “all the trouble he got into was, it just seemed to get worse and worse and compound more and more until I didn’t trust him” (F6). In sum, a number of parents saw themselves as contributing to the very problems that got their children involved in therapy.

Overall, these family members generally did not see themselves in the problem. The problem was viewed as “out there” in their child. The families in this study felt the frustration caused by the child’s bad behavior, poor relational skills, school and legal concerns and medical complications. Because of the loss of control, only a few considered that their relationships with the index person might have been a factor in precipitating the need for therapy. Therapy started with the family generally telling the therapist whom they wanted and what they needed to be “fixed”.

## **Domain 2: Family Experiences Therapy Outcome as Good or Positive Changes in the Index Person**

When satisfactory change had occurred in the family’s way of dealing with the index person, the index person made a number of significant changes that convinced the family that lasting change had occurred. The family saw numerous instances of improved relationships with others. The index person had friends.(F1,

F3, F8) "He's had his share of friends lately".(F1) "She's not hanging with the crowd she was hanging with".(F8) The index person also had a relationship with the opposite sex. (F1, F8) Asked who the girl friend was, the little brother responded, "Michelle, but the old one used to be Randy".(F1) "The boy friend had replaced some of those elements that we were concerned about, so there's been some changes there".(F8) The index person got along better with siblings (F1). The index person also had better relationships with the parent and other adults (F1, F3, F4, F5, F6, F8). After supper, one parent reported, the index person "would sit at the table after everybody else was done and talk. He never talked before" (F1). A step-mother commented, the index person "still has times when she wants to be left alone but when she gets home at night and stuff she'll sit and talk to us and she used to just walk through and slam the door".(F4) After one mother had taken away the index person's booze, "she gave it back the next day".(F6) Asked to explain how what she and her daughter now talk about, one mother remarked, "She and I have discussed quite a bit about [a friend's] pregnancy. Some of the realities of life have kinda struck, you know, close to him with friends and so that has really hit home with her".(F8) Families could also see that the index person had become less reactive and more emotionally mature. Fewer over-reactions and explosions were reported. (F1, F3, F4) "He was upset for a couple of days and that was it. So that's a big change, he's not having these over-reactions".(F1) "[The index person] will walk up to you now and he'll have a smile on his face, and he never used to smile".(F1) "He's got a good attitude".(F3) "She made a big change; instead of denying everything she started being more honest".(F4) "She apologizes to us".(F4). "One

thing we need you to try to work on is trying to control your anger when we do say 'no' and she has improved quite a bit over that".(F4) Some index persons have shown a willingness to learn from parents. (F3, F4, F6) "She admits being wrong sometimes".(F4) "He's much more responsible".(F6) Asked how he felt about his dad, one index person commented, "I didn't want to give him up. I really didn't know what to do for a while and then I figured I wanted to be with [Dad]".(F3) One index person also gave credit to his father for helping him learn how to express his feelings, "all I did was watched (sic) him and learn how to do it".(F3) A parent noted, "she apologizes to us, and that's something I really wanted her to do, learn how to apologize, admit being wrong sometimes" (F4). A father also noted, "The only problem she had was when we did say 'no', she still got angry and we told her that right up front, say, that's one thing we need to try to work on is to control your anger when we do say 'no'. And she has improved quite a bit over that" (F4).

Another area of improvement was in being responsible enough to be employed (F1, F3, F5, F6, F7, F8). "According to what everybody tells us about his job, he did a heck of a job detasseling. They moved him to supervisor after the fourth day," a mother pointed out with pride.(F1) Asked what he like about his job, the index person said, "All the money I made is going towards college. And I have plenty for college".(F6) "He chose to go to work for someone else and, at the time, that was best".(F7) Families also remarked on improvements in the index person in doing chores and work at home (F3, F4, F5, F8). "She actually does things without us asking, like cleaning the house up or doing something around the house.... And she does her normal chores pretty regular now where we don't every have to tell her



anymore" (F4). "He's growing up, I saw him put the tools up" (F3). "He helped me last week. We were hanging trim and he had kind of a boring job but he worked pretty good until noon...." (F5)

Overall, nearly all families with a good result redefined their view of the index person as someone who is maturing or "growing up". "I think he sees now more consequences of his actions where he didn't before" (F1). "Oh, he's grown up a lot of ways, I'll admit that one", one father commented (F3). "I've improved; comes with age, I don't know", said an index person (F6). His mom responded, "he's much more responsible, I mean, he works, he can manage money, he can do a lot,.... [He] grew up. [He] accepted things that he had no control over" (F6). Another mother stated, "Well, I think [she] matured...she became a little more responsible.... I don't think it was as good then as now, you know, it is an ongoing thing, with maturing, but I think it did improve" (F8). Concomitant with changes of the index person, families also redefined the parental contribution to the therapeutic problem when the outcome was positive.

### **Parental Changes**

Parents of the eight families who had a positive outcome experienced significant changes at the same time the index person was changing. Three types of changes occurred. Some of these families changed their skill level for handling specific problems in the family. Other families experienced a notable improvement in their level of confidence or self-esteem as parents. A third group of parents also became stronger leaders in the family. A strong leader was viewed as a person who

was more capable of initiating positive changes or empowering situations in the family.

At the skill level, some parents learned to be more assertive with their children, confronting the index person when needed (F1, F4, F6). One family decided that they should write everything down so everyone could remember what was said and agreed to (F4). Asked how she confronted her son, a mother remarked, "He was always reporting in to me and I wouldn't lie for him [to the probation officer]".(F6) Asking to leave the interview early, one index person was confronted during the interview: "I'm an adult now" brought Mom's response "No, adults are eighteen and over" and Dad's response, "act like one then". (F1) Other parents learned to become more flexible with the children when talking out problems. Asked if he had gotten a lot of lectures, the index person said, "Yeah, but I take it most the time as information".(F3) "It just got to where we weren't arguing, we weren't yelling really. We were getting along and we started understanding each other".(F3) Asked how the therapist had helped, a father said, "He taught us how to communicate with each other, how to bring out feelings without holding it in".(F3) One parent indicated he was learning to express his feelings: "It's just how you express it to others. You don't say it in a nasty way".(F3), Some learned to say "I'm sorry". "We learned how to make up [after arguments]". (F4). Another parent gave up control of the child's allowance; "I told her I'd spend a certain amount and she could buy whatever she wanted with that money".(F4) One parent learned how to argue: "Now we argue and then we sit down and talk about it".(F6).

Some parents became stronger and more in control of themselves which contributed to an increased sense of self-esteem. One mom indicated that she no longer could be prodded into a reaction by the index person, and had stopped feeling guilty when she told him 'No'; "I'm one tough cookie, now" (F1). The same mom had also learned to give up responsibility for some situations at home. "I just gave that job up and let Dad handle it". (F1). Another mother affirmed that she had grown up. "I learned how to handle being a single mother, what to do during stressful time periods".(F2) "Now I know what I'm doing as a mother. If I get stressed out from [index person] being naughty, he goes into time-out or I go in another room for a while".(F2) "Being an independent and single mom, yeah, I'm ready to do it, more than ready" (F2). Other parents felt equally confident about their parenting as a result of becoming more consistent (F4, F6). "We learned to be consistent on what we decide and set the ground rules and follow these and make sure we stick to them".(F4) "I kept him on a real short leash. I mean, you have to be home at 9:00, and I want to know where you're going and things like that".(F6) "I'm not going to let him slide either this year. You know, I'm staying on him".(F1)

One parent had decided she could not be a good parent and remain isolated, so she had reached out to her physician, to her parents, to her paramour, to her paramour's relatives, as well the therapist for support (F2). Three parents stopped taking themselves so seriously (F1, F4, F8). One parent commented, "My favorite [retort] is, 'Yep, you're right. I'm the worst mother in the world. I agree there's not anyone worse than me. I'm proud of it'" (F1). "I tried to use more humor with her".(F8) As parents got more confidence in their ability to influence their family positively, some

stopped trying to force a solution on the index person (F2, F8). "One thing was they loved to play these songs with all the explicit lyrics, but it's not as big an item now. In the scope of things that's been dropped down on the list of irritations".(F8)

A third group of parents became more active in their ability to be a family leader and proactively create situations that would help the family resolve the problem. One parent began to try to see the problems the family had from the index person's point of view, and switched from an emphasis on what he was doing wrong to his strengths (F5).

Well, I can kind of see his point, too. Here we are sitting down and all we're doing is picking out the bad stuff. Pretty much the bad stuff and now we're going to fix the bad stuff and that can't be too pleasant to sit there for an hour and say, this is what I've done bad all week, and they're trying to fix me.

Maybe a guy should look at what a..., look at the good points and then try to figure out...if he had a good week or whatever.

Others started having family suppers so the index person would have more chances to interact with family members (F1, F4). "During the school year we were trying to get at least three suppers together a week, you know, whole family at this table talking".(F1) Another family realized they had become over-focused on the index person and switched to another focus (F8) or became more balanced in the relationship with all the children in the family (F10). One father commented, "Having another person come in, look at the way the family was, I mean,... we got so wrapped up in issues with [index person] I found myself I had lost how to observe the other kids". (F10) One mother objected to the father's involvement in the family,

so she moved him out of the house. "He didn't decide, that was something I decided for him..., I started packing his stuff for him and put it out in the garage." The parents in this third group made a "paradigm shift" (F10) and recast their problems into new situations.

Parents from families who had a positive outcome saw definite changes in the behavior of the index person. The index persons seemed to have a brighter attitude, were more respectful towards parents, and became more responsible for their own behaviors. Family members started doing things together again (F4). Many parents effected similar changes in their own behaviors. Some of the changes were new solutions to the old problems, e.g., changing communication patterns, changing occasions when the family could communicate, communicating with less hostility, etc. Other changes were more dramatic, representing a change in the way the family operated. The index person no longer seemed to be 'stuck' in a hostile, distancing pattern of behavior. These families now began to demystify the panic they had once felt and began to view the index person as "growing up" or as being more "mature". The change in family perspective represented a paradigm shift from seeing the index person as a problem or as a person who created problems to a new focus on the relationship between the index person and the parents. The old problems of the index person no longer seemed to bother these families as much. Although the problematic behaviors may still have been in the family, now they tended to be viewed in a more relaxed way.

### **Domain 3: Family Experiences Therapy Outcome as Poor or Ephemeral**

How did the family know that the therapy outcome was poor? The family could tell that not much had changed, that problems were still ongoing in the family. In addition, the family who felt the outcome was poor regarded any changes in the index person as being temporary. The family might have said that the index person “manipulated” the therapist (F9) or “fooled” the system (F10) by pretending to change. In these two families, therapy outcome was viewed as ephemeral or temporary. Thus, changes by the index person tended to be discounted or disqualified by the family.

The index person was viewed as continuing to be “stuck” in the hostile mode towards the parents and siblings (F8, F9, F10). In response to a question about what was a bad attitude, one family said, “I think all of it is attitude, attitude toward cooperation, attitude towards people”.(F8) “People would always say to me, ‘Well you make her.’ Well, dang, you bring a gun over at certain time next week and we’ll both make her. I mean, my daughter, she does whatever she wants”.(F9)

Simultaneously the parents often tended to feel that the therapist was “picking on” the parents (F10), e.g., “if somebody would have took the time to listen to what the problem was and focused on that instead of thinking [about what the parents did]”.(F10) One parent shifted responsibility for change in the home to the child. “He had to do it himself, and it more or less had to be a one-on-one with him.... It was just a matter of time for him to look at it and say, yes, it’s my problem, I have to take care of it”.(F10) In response to a question about the pressures the parent felt, a mother said, “People kept saying you ought to be the chief agent of change for

[index person], you have to change her, and that was never working at all, plus you always felt down".(F9) Some also felt that if the therapist left, things would deteriorate. "Yeah, there's no doubt he changed a lot, there was less arguing. But after [the therapist left] it started to get more arguing".(F7) Asked about his thoughts during the course of therapy, a parent said he was thinking, "Deep down it's great that we have [therapy] still happening, because the minute it stops he'll stop going to school".(F10) "We were just at a stage where we pretty much felt like that the [therapy] situation was a failure and we had to something or we were going to reach ... a point of no return".(F8)

Overall, the families who viewed the outcome as poor separated the progress the parents might have made from any connection with the index person. Therapy helped the parents cope with the child's behavior, but really had not been useful for the child. "We tried... sending him to his room, but it's not something that works".(F5) "If it's something he don't want to hear then he just... turns the channel or just shuts himself off".(F5) Other parents commented that they had gained positive control of themselves. "We learned from a parental standpoint a lot of things..."(F8) "We probably learned more than he learned out of the deal, how to cope with him".(F5) "What I learned in the process was how to control my emotions better".(F8) Asked about his lack of control, a father suggested therapy had helped him "to some degree, to try to understand that there are some things I can't control, and there's some things I can".(F8) Another father commented, "I think I learned a few things from [therapy]. It was nice to have someone here to observe and see things, and the therapist had a very unique way of describing things, I liked that, and I picked up

a few things here and there".(F10) But a mother, in answer to a question about how therapy helped her, replied, "It didn't, 'cause I didn't feel like the therapy was supposed to be for me, but the court order did say family therapy, but I didn't feel like I was the one who needed it".(F10)

For families with poor outcome, the connections between parents and index person were de-emphasized. The parents and the index person seemed to exist in two different worlds, although they resided in the same household. Consequently, families with a poor outcome continued to focus on the index person. The index person was viewed as a problem, or the index person still had a problem. "He doesn't seem to learn".(F5). Asked about sending her son to his room, a mother replied, "He doesn't like that. Whether it really helps in the long run, it might cool it down but it doesn't seem to".(F5) Questioned about his sense of confidence, a father suggested, "I don't know if I'm anymore confident because [the index person] went back doing the same things he was doing back at that time [when therapy began]".(F8) Asked why she had been ready to stop therapy a mother remarked, "[The index person] wasn't learning anything anyway".(F10)

Therapy therefore became at best a time when the parent unloaded the burden of the "bad" index person (F9). These parents generally resented therapist efforts to get the parent to prompt changes in the index person. [We] "felt we were being roped into something that wasn't really part of our thing".(F10) One parent resisted efforts to hold the index person accountable. Asked how she prevented her daughter from running away, a mother said, "How are you gonna tie them in [the home]? Are you going to duct tape them"?(F9).



#### **Domain 4: Family's Experience of Termination**

The experience of termination related to how the family ended therapy.

Those families who had a positive outcome went through a series of steps as they stopped therapy. For those families who had a poor outcome, therapy may have stopped without their permission. This happened sometimes when the local social worker decided not to renew the contract for additional services. Occasionally, also, the contract may not have been renewed because the therapist had been unable to convince the social worker that progress was being made or was being maintained in the family. In those two scenarios, a family may have continued to request therapy but have had their request denied or ignored. Additionally, the index person, given the choice, would have stopped therapy very early in the process. For all families who had stopped therapy, every family but one indicated they would try therapy again if they had a crisis of sufficient magnitude.

##### **Positive Outcome: A Proactive Process**

Families with a positive outcome usually described termination as a three-step process. First, for many families the therapist suggested the idea of stopping. "Once we had talked about stopping";(F2) "it was kinda a mutual things between the three of us";(F3) [the therapist] told us what her opinion was. She thought that we were doing fine";(F4) "basically we weren't making much more progress and [the therapist] made suggestions".(F5)

Second, the family thought about the suggestion and weighed the gains and continuing problems (F1, F2, F3, F4, F6). "She thought that we would be fine without [therapy]. But, she still left it up to us".(F4) "Well, it really didn't look like it

was going any further than it already had".(F1) "Once we had talked about stopping I think there was probably about two or three more sessions just to make sure I was ready".(F2) What one family wanted from the therapist concerning termination was "something to just, you know, checkup and say, hey, how are things going".(F7)

During the second, considering stage, families often noted that the seriousness of their talk had been waning, that they had been meeting less frequently, there had been fewer problems to talk about, their discussions had become more "fun" and "chit-chat", and their therapy sessions had tended not to last as long. "The therapist had stretched his visits out".(F6) Some families sought reassurance from the therapist that if they stopped therapy, the therapist would be available to come back, drop in, be available by telephone, or go to bat for the family to renew services. "We wanted the therapist to call us up and say, 'You got anything we need to see and talk about'"?(F7) "She gave us her phone number and everything and we haven't even [called]".(F4) At some point during the thinking period, the family decided to take ownership of the idea to stop. "I think it [stopping] should be up to the family".(F1) "As far as ending, don't let somebody tell you you are finished. Make that decision on your own. 'Cause nobody else knows when you are ready".(F2) During the third stage, some families began to negotiate with the therapist when to stop, or how to stop. For some, the decision to quit seemed to be an easy decision and they informed the therapist what they had decided. These families did not feel rushed to termination and expressed their confidence in their own ability to confront future problems. "I knew if I ever had a question I could call her [the therapist]".(F2) "We went through the Department of Human Services and

they offered that if we ever wanted family counseling to let them know".(F4) Asked why they stopped, a mother said, "He was doing real well as far as making good decisions, so he got off probation".(F6) For some families, the decision to stop was considered more of a mutual decision arrived at after a longer period of negotiation between the family and the therapist. "It was a mutual thing".(F6) "Basically, I think the decision was well, it was [the therapist's] and mine".(F2) "It was kind of a mutual thing between the three of us".(F3)

### **Poor Outcome: A Passive Response**

Families with a poor outcome tended to view termination as abrupt or involving no process. These families remembered termination as something that happened to the family but outside of the family's control. A family member remarked on stopping, "The therapist just stopped coming" (F7). Another said, "The therapist just disappeared" (F9). "We never had a choice. It was dictated to us".(F9) Others noted that the service contract with the social worker had ended (F7), or that the social worker refused to renew it. "Well, you know, the social worker, like they have so many sessions they pay for, it's like contracting".(F9) One family who had a poor outcome had already decided that therapy was not working, so the family itself had decided to quit. "[The index person] had problems going into the program, but they were magnified by or supported by some of the other individuals that were in the program".(F8). In one instance the family felt that the index person had gotten worse and the family was in more crisis because of therapy, so they desired to stop in order to obtain a stronger intervention elsewhere. Two of the four families with poor outcome had never considered stopping therapy and expressed surprise,

consternation, and anger when termination occurred. (F7, F8) In either case therapy just stopped; no steps were followed which brought the family to the end of therapy. Someone outside the family decided that therapy had ended or the family just quit.

### **Index Person**

Based on the second contact with each family (Appendix 8), all families agreed that the index person was generally the first person who wanted to stop therapy without regard to the outcome. While two index persons expressed an appreciation of the therapist for the "fun" they had (F3, F6), both index persons would still have preferred to stop much earlier. Every parent contacted agreed that if the decision had been solely in the hands of the index person, therapy would never have started or would have lasted at most two weeks. In family therapy parlance, the index person always believed in brief therapy.

### **Re-entry into Therapy**

Nine of the ten families interviewed, regardless of the outcome of therapy, indicated that they would choose to have therapy again if they had a crisis that warranted it. Some families indicated that they would require a more dire crisis than others to return for therapy (F5, F7, F8) would. Other families viewed therapy with much less suspicion and would have recommended it as the first choice for families who might have had serious difficulties (F1, F2, F3, F4, F6). Several families had in fact gotten other counseling or mental health services since termination (F1, F6, F8, F9), most with positive results.

### **Domain 5: Family's View of the Therapist as Related to Termination**

All the families appeared to like the therapist regardless of the outcome of the therapy. However, having a good relationship with the therapist did not appear to have influenced them relative to termination. One parent said, "We liked the therapist, but he wasn't family; we didn't want him coming the rest of our lives" (F3). If the therapist did have any influence concerning termination, it related to the timing of termination. All families who terminated with good results reported that the therapist had been the first to bring up the idea of stopping.

### **Domain 6: Family's View of the Social Worker as Related to Termination**

As the analysis progressed, the researcher noted a number of families seemed to have an animus towards the social worker. Responding to this emergent finding, the researcher asked later families in their interviews how their relationship with the social worker might have affected their decision to stop. In addition, during the member checks each family was again asked to characterize their relationship with the social worker and how that relationship might have impacted the family's decision to stop therapy. Seven families indicated a less than optimal relationship with the social worker. One family indicated that the social worker was "awful" (F9). Five other families reported the social worker to be difficult to talk with. Four families regarded the social worker as good, fair and okay. Consequently six families expressed some hostility towards the social worker, regardless of the outcome of therapy, but all but one (F7) indicated they would avail themselves of therapy again if they needed to. On the whole, although some families may have had ambivalent experiences with the social worker, the relationship with the social worker did not

appear to affect their decision to stop therapy and would not deter many of them from requesting services again.

## CHAPTER 5

### DISCUSSION

#### **Implications for Termination of Therapy with Families**

Families who were ready to terminate were those families who had made a paradigm shift. The family who experienced a positive outcome in therapy had changed from a focus on the identified person as the problem to a focus on the index person as someone who was "growing up". Simultaneously the parents had begun to focus on family relationships in the home. The parents feel empowered and more confident about being consistent when they need to be. The family felt stronger and more capable of handling a crisis should one arise. The spotlight was off the index person and was now on how the family members influenced each other in daily activities. The family felt confident in their communication with each other. Each family member felt that other family members would listen to all concerns and points of view. Families who had made this paradigm shift demonstrated a readiness to terminate family therapy when the therapist suggested it.

Families who had a readiness to terminate generally followed a three-step process in ending therapy. In the first step, the family did not initiate the suggestion to terminate. They waited until the therapist suggested it. In the second step, the family considered termination. The consideration stage frequently included a slow-down in frequency of meetings, shorter sessions, less problem-related talk in the session, and more general conversation with the therapist. In step three, the family took ownership of the termination decision and negotiated the end with the therapist. In the negotiation stage, the family typically felt emboldened to stop therapy when

they had assured themselves the therapist was willing to stay in touch, would get back to the family if needed, might drop in to see the family, or would help the family start additional services if they got desperate again. Termination, however, did not seem inevitable in these families. Without the therapist acting as a trigger, the family may have continued to meet. It might be fairer to suggest that termination issued from continuing conversations between family and therapist, i.e., that the decision to end was socially constructed, and hence, in the family narrative, the decision was remembered as mutual.

Readiness to terminate may be the most significant suggestion to arise from this study. Readiness appears to be connected in these families to a redefinition that shifts attention away from the index person and a renewed confidence in the parent's ability to influence family relationships as the child grows up. If this hypothesis were to be supported in further research, readiness would seem to have a predictive quality, enabling therapists or gatekeepers to anticipate termination of services. Are there signs that a family gives that might clue readiness or the approach of readiness to terminate? Confirming a readiness to stop might be quite helpful as those in the mental health field who strive to cope with shrinking resources. A second hypothesis addresses connection between the redefinition that signals readiness and which type of family more likely to need services again. In the member checks, two families indicated that they had had serious crises related to the index person in the three months since the research interviews. In both cases, the parents indicated that they had considered asking for more counseling, but decided they could handle the crisis themselves. Both parents also disclosed the



strategy each had taken to handle the crisis and how each felt the crisis had dissipated. Both of these families had had positive outcome in therapy.

Families who had a poor outcome were a sharp contrast to the families with positive outcome. Families with a poor outcome did not make a paradigm shift and continued to stay focused on the index person and his or her problems. Adults in the family tended to discount or disqualify parental influence on the index person and parental abilities to impact family relationships. They continued to point to the index person as the one who needed 'fixing.' These families also expressed ample frustration because the therapist had failed to pay enough attention to the 'real problem', the index person, and expressed resentment that so much attention had been given to the family. Furthermore, for families with poor outcome, some wanted therapy to continue because the index person still had not been 'fixed' while another wanted to terminate because the index person had not been 'fixed'. Two families expressed an interest in finding another intervention or another outside agent, usually something or someone more intense, who might perform better at holding the index person accountable. Some families with poor outcome also regarded termination as an imposition, done without their consent. These families tended to be mystified by the uninvited termination of therapy. Certainly, it appears harsh that counseling services might have ended without letting the family know it was going to happen. Perhaps the message delivered but ignored by the family, or perhaps the family never got a message. However uninvited termination occurred, each of these same families predicted failure for the index person because therapy had been withdrawn.

Positive regard for the therapist was not in itself a factor in the decision to terminate. All families, those with positive outcomes and those with poor outcomes, expressed a high regard for the therapist. Families with positive outcomes, however, did not wish to extend services just to continue the relationship. Families with positive outcome did like to have the assurance that the therapist may contact them later to 'touch base' with them, but the high regard did not lead them to continue services. Families with poor outcome who expressed themselves as wanting interventions that are more serious do not allow high regard for the therapist to enable them to apply for more services with the therapist. Poor outcome families who wanted therapy to continue but had it terminated any way continued to have a positive regard for the therapist. In sum, high regard for the therapist did not seem to influence the decision to terminate.

Most families expressed an animus against the social worker. Some families appreciated what the social worker had done for them. Some families felt the social worker was somewhat rigid, but did a reasonably good job. It is not clear how hostility towards the social worker might have affected any family's decision to terminate or to accept termination.

The initial focus on the index person is not surprising. The process of referral by a social worker depends on identifying some deficit in a child under the age of eighteen. Entry into family therapy through a local Department of Human Services would naturally be influenced by a social worker's characterization that the crux of the family's problem is focused on a given index person. The social workers in this population tended to emphasize deficits, and the federal government pays for

services focused on deficits in children. Our society's prevailing stance in the mental health field is a medical model based on deficits. When families accepted the "prevailing wind", they would naturally focus on the index person's problems. Given that tendency, the paradigm shift that some families made and their readiness to terminate seem that much more surprising.

### **Implications for the Therapist**

This study underscores one of the realities that therapists face in working with families where the index person is a child. Allgood and Crane (1991) report that families who identify the problem as residing in the individual are more likely to dropout of therapy than families who see the presenting problem as relational. Many other persons in the family constellation colluded with this individualized point of view. The parents are often aiming at the child. The social worker is singling out the child. The school is holding the child responsible. The medical establishment is focused on the child. Then comes the therapist with an emphasis on the relationships in the family system. Even if the family could make a switch from child focus to a family relationship redefinition, it is not clear who could convince other partners in the therapeutic endeavor that a dramatic change has occurred. This study helped support the principle that relational problems should be the focus of therapy by demonstrating that families who refocused their energies on relational concerns in the family were ready to stop therapy. Readiness to stop therapy should be viewed as an encouragement for governmental entities that paid for the therapy.

Obviously some families made the redefinition and some did not. In this study those families who made the redefinition had positive outcomes and showed a

readiness to terminate. The families who did not make the redefinition had poor outcomes and were often ambivalent about stopping or continuing services. For the families with poor outcomes, the readiness to terminate was missing. Therapists might be interested in at least two aspects of these phenomena. First, what makes some families switch to a relational view of the problem and what impedes other families? Second, is readiness to terminate a phenomenon that the family signals before termination, or is it an ex post facto perception by family members?

### **Implications for the Family Researcher**

The role of the family voice (Gilligan, 1982) as evidenced in this study is strong. Families have definite contributions to make in understanding the role of that renewed confidence can play in overcoming family problems. Since therapy is essentially a constructed system of meaning that issues out of the interplay between family and therapist, accessing the family's voice, as this study does, is an important contribution to the family studies field. Bischoff & Sprenkle (1993) complain of the lack of family input in making assessments about the efficacy of therapy and the stability of families facing developmental pressures. This study answers in part the call for that kind of study. Furthermore, renewed confidence among the parents to deal with mostly adolescent problems might have been a significant discovery for studying these families. How do families renew their confidence? Was the renewal of confidence inevitable in those families with positive outcome? Are there patterns of behaviors which trigger this renewal of confidence? Are there resilience factors in families (Boss, 1988; Falicov, 1988) which enable some families to achieve the redefinition that other families are missing? Further research to answer these

questions may lead to a stronger understanding of how some families succeed so well in getting out of therapy and others do it so poorly.

### **Conclusion**

In conclusion, how families experience the end of therapy has been neglected far too long in the family therapy field. This study, though quite limited in scope, has several suggestions for a better understanding the end of family therapy. In some of the families studied here successful therapy eviscerated the sense of crisis and restored a balance in family relationships. These families succeeded admirably by moving away from a focus on the index person and gaining a redefinition of their relationship with each other. They now viewed their miscreant children as “growing up” and saw their own parenting efforts as a contribution to the child’s maturation and development. For these, termination was a process, suggested by the therapist, but reflected on and decided by the family.

Other families in this study did not achieve a re-balancing of relationships. They remained focused on the misbehaviors of the index person and frequently regarded the child as dysfunctional in some way. In fact, some suggested that therapy was a misguided enterprise centered too much on parent-child relationships to the neglect of the index person’s problems. These parents continued to desire that their wayward child be “fixed”. For the families still focused on the dysfunctional index person, termination seemed merely a halt in services. No decision was actually experienced by the family. The ending just happened.

The crucial suggestion that emerges from the study of this very small selection of families is that those who regain a sense of influence in the maturation

process of their child decide when and how to end therapy. The termination process is isomorphic to the very therapy accomplishments that brought them to the moment of closure. Those who do not achieve a sense of influence often are not ready to stop and tend to see therapy as a disjunctive effort. The therapist's efforts and the parents' efforts are not perceived as congruent and the ending of family therapy is thus disappointing.

## **APPENDIX 1**

### **PROPOSAL TO WEST-IOWA FAMILY SERVICES, INC.**

#### **Termination: How Family Members Experience the End of Family Therapy**

Proposal for Research at West-Iowa Family Services, Inc.

Henry B. Grant, M. Div., M. A. Ed.

Research for completion of Ph. D. in Human Development and Family  
Studies, Specialization in Marital and Family Therapy.

Iowa State University

Ames, Iowa

Supervising Professor: Harvey Joanning, Ph.D.

#### **Purpose of the Study**

As an in-home family therapist in this organization as well as in other organizations with which I have been associated, I have often noticed that families seem to sense that it is time to end before the therapist is ready or before the therapist is aware that the family is growing disinterested. Something may have 'clicked' in the family collective will which starts family members thinking about stopping therapy. Sometimes the family, unable to get out of therapy when they want to, begin to dawdle in their progress and begin to 'drop' signs to the therapist that they are ready for closure. With the advent of social constructionist therapy, more attention has begun to be paid to the role of family members in the co-construction of therapy. Readiness to stop and how family members arrive at that tacit decision may fit well into the social constructionist paradigm that emphasizes an

equal role of the family members in the process as well as direction of therapy. This study will take a first look at the experiences of family members in the explicit and/or tacit decision to stop therapy.

### **Research Design**

The researcher will use qualitative research methodology in this study because there has been so little previous research into this area. Ten or so families will be selected for interviews concerning the progress of therapy and their decision to stop therapy. Each family will be interviewed once, and three of the families will be contacted at a later time by telephone to check to see if the findings are congruent with their experiences. The researcher does not intend to interview any families twice, so there will not be a need to record names and addresses. Each participant will be given a number and a designation (a,b,c) reflecting their position in the family, but no personal information will be kept that could identify the family or family members at any later stage in the study. All interviews should be concluded by the end of the month of May, 1999, with the proviso that the study is using an emergent design which may enable a shorter window or necessitate a longer window, depending on the initial findings.

### **Data Analysis**

The data will consist of transcript narratives taken from audiotaped interviews and researcher field notes. The transcripts will be analyzed by a team of two researchers using an adaptation of the Developmental Research Sequence recommend by J. D. Spradley (1979) with an addition by R. Tesch (1990). Commonalties and uniquenesses will be described from analyses of the data. In this



study, the researcher will not be using any statistical analysis. Because of the way the study is set up, the researcher will make sure that all descriptions of participants will be kept anonymous so as to protect the confidentiality of participant responses.

### **Potential Benefits**

The proposed study will have a number of potential benefits for West-Iowa Family Services, Inc. First, the research will be accessing client perceptions of the process of therapy, the perceived progress of therapy, and the termination of therapy. This valuable information should help the organization make a better evaluation of how family members tend to regard the services that West-Iowa Family Services offers to families. Second, the study will zero-in on the process of termination and how family arrives at the decision to stop therapy. Third, this study should help West-Iowa Family Services better focus the therapist on the ideas of preparing for termination. Fourth, this study will correlate research that is being done presently through the Iowa State University marital and family therapy program with therapy offered through a private agencies. As managed care becomes more pervasive in the therapy field, more consideration will have to be paid between those in the university and those in the field on how therapy is conducted in the home of the client compared to the office of the therapist. Finally, should any additional research and/or publication come from this study, the contributions of West-Iowa Family Services to the process and outcome will be publicly acknowledged.

### **Potential Risks**

This research of this study is not intended to cause any discomfort or deception for the participants. Participants will be contacted by telephone to seek

permission to interview. Letters will be sent to each family who assents to the interview to outline clearly the focus of the study. Additionally a form for Informed Consent will be sent to the family. The Informed Consent letter must be signed prior to any interview. All the participants are expected to participate voluntarily and no incentives will be offered. While the researcher expects that all family members who participated in the therapy will participate in the interview, if any persons object to other family members participating, the researcher will attempt to make accommodations so that the largest number of family members may participate. While confidentiality will be expected to be close to 100%, the researcher must acknowledge to the family that the researcher can only be responsible for what is said in the study , not what the family members will say outside the interview.

### **Confidentiality and Consent**

During the analysis of the transcripts, each family will be identified with a number designating the family. Each family member will be designated with a letter corresponding to their position in the family, e.g., parents, identified person, sibling, paramour, step-child, etc. The researcher does not plan a follow-up interview, so names and addresses of participants will not be kept. The Informed Consent forms will be signed by the participant family members. The signed forms will be kept separately from any data.

### **Conclusion**

I appreciate the consideration that West-Iowa Family Services, Inc. will give to this proposed research. I believe that the results of my study will be both interesting to West-Iowa and West-Iowa staff as well as informative about the course of therapy

and its conclusion. If you have any questions and/or concerns, please feel free to contact Henry Grant by telephone, 515 233-0584 or by email, [hbgrant@netins.net](mailto:hbgrant@netins.net).

Thank you.

**APPENDIX 2****PARTICIPANT INFORMATION LETTER**

*Name*  
*address*  
*City state zip*  
*Area code, telephone #*

When I called you recently I told you I would be sending you a letter describing the kind of research I am doing and what I hope to accomplish as a result of this research. Before I get to the 'nuts and bolts' of my research, let me first introduce myself.

My name is Henry Grant. I am a family therapist employed by West-Iowa Family Services, of Denison, Iowa where I work with [name of therapist], who gave me your name. I am also a student at Iowa State University, getting a degree that specializes in marital and family therapy. I am married and have three children, one grown-up, one in college, and one at home. I live in Ames, but work in Denison.

In my research I am trying to find out how families decide to stop therapy. I know that each family decides in a different way. I am interested in finding out about your experiences of ending therapy, how you decided to stop, and what convinced you more and what wasn't very helpful in your decision to stop. As a way of setting a context of your decision I would like to hear a little about how therapy started for your family, what you learned, and how you got out. Frequently therapists ask other therapists about how therapy ended. Seldom do we ever ask the family. I would like to ask you what your experiences were.

I am including an Informed Consent form, which I will need for you to sign before we can begin the interview. The interview should not last more than an hour. I will expect to audio-tape the conversation so I can be sure I am getting all that you have to tell me. Once the audio-tapes have been transcribed, any information on them will be kept strictly confidential and no identifying information will be put on the transcript that could lead anyone to identify you or your family members. If you have additional questions, please feel free to contact me at my home (515 233-584) or through the West-Iowa Family Services office in Denison (712 263-8445).

Sincerely yours,

Henry B. Grant

### APPENDIX 3

### INFORMED CONSENT

*Name*  
*address*  
*City state zip*  
*Area code, telephone #*

The Department of Human Development and Family Studies, Iowa State University, and West-Iowa Family Services, Inc. recognize the importance of the protection of human subjects participating in research studies. The following information is provided so that you may decide if you are willing to participate in the present study that will be used as part of a doctoral dissertation. You should be informed that even if you agree to participate, you are free to withdraw at any time.

The purpose of this study is to access the experiences that family members have of the process of ending or "stopping" therapy. The researcher seeks to learn how families reach the decision to stop, in order to help other families and therapists understand what families are going through when therapy ends.

Your participation in the study shall consist of one interview (approximately one hour) with the researcher. The interview is not intended to cause you any discomfort or deception. The interview will be audio-taped and the audio-tape will later be transcribed into a typed, written record. Each family will be given a number to identify it and each family member will be given a letter designating its position in the family. No family names or personal names will be recorded on the transcripts. At the conclusion of the study, all audio-tapes will be destroyed. Most of the families interviewed, of which you may be one if you agree, will be contacted and asked to respond to the early or later findings. This way the researcher will be "checking" with families to see if what we are "hearing" is "true" to your experience.

I/We have read and understand the above information. I/We understand that participation is voluntary and I/we may withdraw at any time.

Signatures of Participants/Guardians and Witness

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Witness:

\_\_\_\_\_

Date:

\_\_\_\_\_

## **APPENDIX 4: RESEARCH TEAM SUMMARIES**

### **4A: Research Team Summary 1**

Research Team meeting, September 10, 1999. The research team met for the first time and got acquainted. Team members are: Henry Grant, Lead Researcher, and assistants: Amy Yates, Ph. D., Adi Granit, candidate for Ph. D. in Marital and Family Therapy, and Kathy Ligon, candidate for M. A. in Marital and Family Therapy. The meeting took place in the office of Amy Yates in Monroe, LA. The proposal of the research was introduced to the team members and consensus was reached with each team member how to pursue the analyses of the project.

The computer software program being used for this research, Atlas-ti was introduced to each member and copies were given to each member so that they could do computer analysis on their individual computers. The general principles of the computer program were introduced and handbooks for questions and guidance were made available for each research team member.

The first transcript, 01Fam6.txt, was introduced to each team member. The lead researcher made a review of how the respondents were chosen and how the first interview had gone. Hard copies of the first transcripts were provided for each team member. The lead researcher reviewed the general principles of qualitative research analysis being employed in this project, and then team members each made an individual analysis of portions of the first transcript. Comparisons were made of each team member's initial analysis and the lead research made corrections as warranted. Emphasis was placed on using the respondents' own words for initial coding categories and researchers were steered away from making

Family Studies categories and terminology as preliminary categories. The lead researcher introduced Spradley's analytical concepts "X is a function of Y" and "X is a characteristic of Y". Each X represents a statement by the respondent, and Y represents a possible coding or memo-ing category. "Is a function of" relates to verbal relationships and "is a characteristic of" relates to adjectival or predicate nominative relationships. In the event that the respondent statement or groups of statements were unclear to the research analyst, then the researcher should use the Spradley's guides for possible classification. Consensus was reached by all researchers on how to do the analysis and all agreed that as the coding progressed other categories might emerge or previously identified categories might need to be merged and unified. Consistent with the emergent quality of qualitative analysis, researchers agreed to code the first three transcriptions and then meet again to compare results.

#### **4b: Research Team Summary 2**

The Research Team met via telephone conference on September 28, 1999. Analyses by each team member of the first 3 interviews, 01Fam6.txt, 02Fam2.txt, and 03Fam3.txt were compared. General categories that had accrued the most citations were listed for each researcher and compared. Consensus was reached that each researcher was seeing the same things in the family interviews thus far.

The lead researcher pointed out the initial interview and a subsequent interview had lifted up concern by family members that they did feel or would have felt it easier to stop therapy if they had some assurance that the therapist would check with them again, or would return for further visits, or would help the family secure additional therapy services. This appeared to be an emergent category of concern. The researchers had labeled this type of request 'Safety Net' in this coding. The interview with family 07Fam7.txt had indicated this safety net feature most strongly, so the lead researcher asked the research team to analyze 07Fam7.txt next. The researcher also indicated that he would be adding a 'Safety Net' type question to the protocol for structured questions.

The different categories of analysis for each analyst is listed below, with no particular order or significance indicated.

Henry (Lead Researcher):

- Advice to other families
- Change in the index person
- Friends of the index person
- Therapy learnings



- Presenting problems
- Changes by the family in therapy
- Complications in therapy
- Deciding to stop therapy
- Reason to stop therapy
- Results of therapy

Amy (Assistant Researcher):

- Advice from the family
- Therapist approval
- Interventions
- Life cycle events
- Parenting events
- Quitting Therapy
- Safety
- Therapy change
- Therapy accomplishments
- Good therapy
- Bad therapy

Adi (Assistant Researcher):

- Background
- Process
- Safety

- Positive experiences of therapy
- Confidence from change
- Behavior change
- Reinforcement of change
- Perspectives of change
- Processes of termination
- Support system

Kathy (Assistant Researcher):

- Alliances
- Ending therapy
- Index Person
- Mom & Dad
- Safety
- Therapy learning

The preliminary analysis confirmed that the research team was seeing basically the same results in each family, so focus was placed on continuing to code as we had been doing, and finding uniquenesses. It was pointed out that the “Memo” feature of the software program, Atlast-ti, allows for citations of text to be classified as unique and that we should not continue to clutter up our coding schemes with individual instances of a particular code, but list the citation with a “memo” and then later return to see if or how it might fit a previous code. The consensus of the meeting gave everyone confidence that we were all being good

instruments in the analysis of this data. The next assignment was to analyze interviews 07Fam7.txt, 04Fam3.txt, 05Fam3.txt, and 06Fam2.txt. The assistants communicated that the diskette of 05Fam3.txt had been damaged in mailing, so they would not be able to complete the analysis of 05Fam3.txt by the next meeting. Team members agreed that another 05Fam3.txt diskette would be hand-carried to Amy to the next meeting and she would get copies of that interview to the other team members.

#### **4c: Research Team Summary 3**

The research team met again on October 9, 1999 in Chicago, IL. Henry and Amy were present. Amy brought written contributions from the other two members for consideration.

Coding was reviewed on the first six interviews, and it was confirmed that all were seeing the same data and the same results.

From the data analyzed so far, the following hypothesis seemed to be emerging from the data:

- Presenting problems related to the index person (IP) are generally viewed as hostility to the parents.
- A change in the Index Person's (IP) behavior is viewed by parents as 'growing up' or 'maturing'.
- Presenting problems do not seem to be related to the outcome of therapy; the usefulness of presenting problems data in this study is primarily as descriptors of the population being studied.
- A change in parenting behavior is viewed by the parents usually as 'getting tougher'.
- When the family indicates that they like the therapist, this is viewed from the family's perspective as acceptance.
- Process of quitting therapy: The therapist initiates the idea of quitting and prompts the family to consider it. The family considers the therapist's idea, claims ownership of it, and then notifies the therapist of their readiness to stop.

- When the family is assured by the therapist that further therapy is available, or that the therapist is available for additional counseling, then the family feels it is easier to quit.
- When the family has already received additional services conjointly with family therapy, or requests additional services from the social service system conjoint with family therapy, the result of having the additional services serves to undermine the family's self-esteem and to disempower them.
- Families that receive additional services, in this study, generally feel they have poor outcome of the therapy offered, and desire to quit therapy as a way of escaping from the social service system.
- If the parents are confident about their ability to 'stay tough' then they good about stopping therapy.
- If the parents accept additional services, this is *prima facie* evidence that they are not confident, but the additional services only result in feeling even more disempowered. Quitting therapy for these families means getting the intrusive social service system out of their lives. Ending therapy then serves to boost their confidence in their parenting ability.
- An adversarial relationship with the social worker is persistent in the family's understanding of why they have services. The social worker tends to view the family as having problems; the parents in this study feel accused by the social worker; the parents feel that the social worker thinks and is working to change the problem in the parents, not in the IP.

- This is a homogeneous population; the presenting problem is identified in the child: but how the family learns to handle the child determines how open the parents are to the therapist's suggestion that therapy should end.
- In this population, the influence of the therapist on the family results in a positive therapeutic relationship, but having a positive therapeutic relationship does not in itself help the family feel that therapy has been helpful or that they can stop therapy.
- The title of this study should be "why families terminate", not "how families terminate". Most of the process of termination is not in this data, except that termination ideas are usually initiated by the therapist. Not much process is articulated in the data analyzed so far.

After further consultation, note was made that an animus against the social service system and against the social worker kept occurring during the analyses, so another structural question should be added to the protocol to solicit the family's attitude towards the social service system and/or social worker and how that may have influenced the family in the decision to stop therapy.

#### 4d: Research Team Summary 4

Emails Exchanged Re: Domains

Subject: Results outline -- give me a response

Date: Sat, 23 Oct 1999 22:24:42 -0500

From: "Henry B. Grant" <hbgrant@netins.net>

Organization: GrantCo Research

To: "Yates, Amy" <geauxyates@hotmail.com>

RESULTS (Chapter 4)

DOMAINS:

##### 1. INDEX PERSON

###### A. PRESENTING PROBLEMS FOCUSED ON INDEX PERSON

##### 2. WHEN OUTCOME OF THERAPY IS GOOD OR POSITIVE

###### A. FAMILY'S PERSPECTIVE OF TERMINATION

- a. Ready for termination
- b. Enough change in family
- c. Parents more confident
- d. Some families like the offer of additional services, just in case the  
parents hit a snag

###### B. CHANGES IN INDEX PERSON OBSERVED BY FAMILY

- a. Behavior changes
- b. Attitude changes

###### C. FAMILY'S PERSPECTIVE OF INDEX PERSON

- a. 'Maturity' or 'growing up' of index person

- b. Focus is off the index person, on the relationship instead

### 3. WHEN OUTCOME OF THERAPY IS POOR OR EPHEMERAL

#### A. FAMILY'S PERSPECTIVE OF TERMINATION

- a. Not ready for termination: more help needed
- b. Ready for termination: have given up

#### B: CHANGES IN INDEX PERSON OBSERVED BY FAMILY

- a. Few changes noticed
- b. Changes have occurred, but do not last

#### C. FAMILY'S PERSPECTIVE OF INDEX PERSON

- a. Index person is still the 'problem' or still has the 'problem'

### 4. FAMILY'S PERSPECTIVE OF THE PROCESS OF TERMINATION

#### A. POSITIVE OUTCOME PERSPECTIVE:

- a. Therapist initiates suggestion,
- b. Family thinks about it,
- c. Therapist comes less often,
- d. Family claims ownership of the decision to stop,
- e. Therapy ends

#### B. POOR OUTCOME PERSPECTIVE:

- a. Family initiates/accepts the end of therapy
- b. Family is mystified because therapy stops

#### C. INDEX PERSON'S PERSPECTIVE



- a. Index person the first to want therapy to stop, regardless of outcome

5. FAMILY'S VIEW OF THE THERAPIST RELATIVE TO TERMINATION

- A. All these families like the therapist
- B. Liking the therapist doesn't influence these families on when to stop

6. FAMILY'S VIEW OF THE SOCIAL WORKER RELATIVE TO TERMINATION

- A. Most of these families have negative experiences: dislike, don't trust, or resent the social worker
- B. Some poor outcome families have animus against further offers of help

because of their negative experiences with the social worker

Subject: Domains

Date: Sun, 24 Oct 1999 16:25:43 PDT

From: "todd yates" <geauxyates@hotmail.com>

To: hbgrant@netins.net

Henry,

So so late today in replying. I had to come up here to the office to download your attachment. I know there is a way to do it on my computer at

home, but I didn't want to take the time to figure it out when I can work so much more quickly up here.

Adi's last name is Granit.

OK, now to the good stuff:

I received your e-mails on Friday. For the most part, I agree with your summaries both of the family and of our meeting in Chicago. What I disagree with is too minute to mention.

Now for the most exciting thing: YOUR DOMAINS!! They are truly wonderful.

I wholeheartedly agree with your results. I am impressed with your synthesis of the data and believe that you accurately reflect the information presented in the transcripts of the interviews.

I am pleased that you chose to interview 3 additional families since our Chicago meeting. I think that this helped with the formulation of such salient domains.

I printed off your domains, and here are some suggestions:

#1-a, may want to mention in your discussion that the IPs in all these cases

are children due to nature of the work of the agency

#2-c, Maturity and growing up were also mentioned as behavioral changes of

other members of the family besides the IP: ex mom, older son

#4, where do the cases that were terminated due to lack of funding

fall? I

know there were at least 2 cases like this

That's it. GREAT JOB!!!!!!

Happy depositing!

Amy

## **APPENDIX 5: VIGNETTES OF FAMILIES**

### **5A: Vignette of Family #01**

Family #01 consisted of six persons: Father (41), Mother (39), and their four biological sons, ages 16, 13, 7, and 5. Father and Mother were married. All members of the family lived together in their own residence. The family resided in a town with a population of 9500 in west-central Iowa. Every one in the family was white. The family members indicated that they attended a local Catholic Church.

At the time of the interview, Father was employed as the assistant manager of a car repair shop and Mother was employed as a certified public accountant. Their income would be considered middle class. The oldest son was employed in a telephone advertising company. The second son indicated that he worked in odd jobs, especially for a local bike company.

The index person of this family was the second son, who had been diagnosed with ADHD and high anxiety. The family indicated that the index person was consistently oppositional to parental guidance when they voluntarily requested counseling services through the local county Department of Human Services. Family therapy was voluntary. Family therapy was provided to this family initially by another agency and then through West Iowa Family Services, Inc. A male therapist was assigned to the family. Family therapy lasted ten months.

Father, Mother, and three sons, including the index person, were interviewed. The eldest son was at work and did not participate in the interview. The index person participated in the interview, but left to 'go work out' about half way through

the interview. The interview took place in the dining room in the family home on the evening of August 9, 1999.

**5B: Vignette of Family # 02**

Family # 02 consisted of three persons: Mother (22), her biological son (2), and her live-in paramour (25). Mother was divorced from her son's father. Biological father had given up all parental rights to the child. Mother, son, and paramour lived in a rented home. They resided in a town with a population of 9500 in west-central Iowa. Every one in the family was white. The Mother indicated she attended a local Protestant church, where her parents also attended. At the time of the interview,

At the time of the interview, Mother was employed in a local factory. The paramour was employed as a manager at a Telephone Soliciting Company. The two incomes combined would be considered lower middle class. The baby was placed in day care while the adults in the family worked.

The index person (IP) of this family was the son, who had been physically abused as an infant. Handprint bruises were filmed on the baby's body. The baby was removed from the home and placed with the maternal grandparents. The handprint size fit both parents, so both parents were accused of the abuse; both parents denied it. Subsequently, as the parents were about to take lie detector tests, the biological father confessed that he had hit the baby numerous times. Family therapy was authorized for the couple, but after the biological father's confession, the couple split up. Subsequently a female family therapist from West Iowa Family Services, Inc. was contracted by the local county Department of Human Services to provide counseling and therapy for the mother. Family therapy was voluntary. Another therapist was assigned to the father, but the father declined

counseling services. Later, the mother reports, the father voluntarily gave up his parental rights to the baby, ostensibly to avoid paying child support. Family therapy was provided to this family for approximately one year. The paramour may have attended some counseling sessions occasionally, but not regularly.

Only Mother was interviewed. Although the researcher was introduced to the paramour, the paramour did not participate in the interview. The baby was asleep during the interview. The interview took place in the kitchen of the family home on the evening of August 24, 1999.

**5C: Vignette of Family # 03**

Family # 03 consisted of three persons: Father (39), his biological son (16), and his live-in paramour (47). Father is divorced from the son's biological mother. That couple had three children, the eldest son (19), and twins, a boy (16) and a girl (16). The eldest son was in prison at the time of the interview. The daughter resided with her biological mother in another city. There had been no contact in the last year between the twins, nor between the twin son and his mother. The family resided in a small town with a population of less than 300 in western Iowa. The Father and the son are both white. The paramour indicated that she is half Native American, from a tribe in Nebraska. The paramour indicated that she had just moved into the home in the previous month. The Father and son both indicated that they attended a Lutheran church *regularly*.

Father indicated that at the time of the interview he worked in a local restaurant. The son indicated that he had just gotten a part-time job at the same restaurant. The Paramour reported that she worked in a social service position in Omaha, NB. The Father owns his own home and considers himself middle class.

The index person is the 16-year-old twin son who resides with his father. The index person had been living with his mother and had been placed several times in institutions for being out of control. In the spring of 1998, efforts to reunite the son with his mother were abandoned and the son was placed with his biological father. In-home family therapy services were offered by the county Department of Human Services to the father to help with the transition. The index person had also been previously diagnosed with ADHD and with an anxiety disorder, for which he received



medication. The father had also reported that the son was often belligerent with him and uncooperative, so he accepted the offered services. Family therapy was voluntary. A male family therapist from West Iowa Family Services provided counseling and therapy for the family. The paramour did not reside in the home at the time of therapy, so did not participate in therapy. The family had family therapy for fourteen months.

The father, index person, and the paramour all participated in interview. The interview took place in the kitchen of the family home on the evening of September 1, 1999.

**5D Vignette of Family # 04**

Family # 04 consisted of four persons: Father (42), stepmother (30), a daughter (16), and a son (2). Father is divorced from his first wife. The divorced wife resides in Texas and has custody of two of their three children, a daughter (14) and a son (11). Father has custody of their oldest child, a daughter. Father and his second wife, the stepmother, have a biological child, age 2. The oldest daughter had been living with her mother, but at the age of 14 in Texas a child may tell the court which parent he or she wants to live with, so two years ago the daughter chose to come live with the father. The two children who reside in Texas usually spend the summer with their father in Iowa. The oldest daughter usually spends two weeks per year with her biological mother in Texas. The family resides in a small town with a population of 2300 located in western Iowa. Everyone in the family is white. Family members indicated they attend a Protestant church in their town.

Father indicated at the time of the interview that he worked as a supervisor in a manufacturing plant in a neighboring town. The stepmother indicated that she had been working but recently decided to stay home and take care of their son. The sixteen-year-old daughter works part-time in a local shop. The father and stepmother own their own home and are perceived by the therapist as middle class.

The index person is the 16-year-old daughter who resides in the home. The index person had been having considerable problems when she was living with her biological mother in Texas. When the index person came to live with her father, she brought many of the same dysfunctional behavior patterns with her. Additionally the index person had difficulty adjusting to her stepmother who is just fourteen years

older than she. The stepmother also had difficulties adjusting to having a teenager in the home during the time she was pregnant and after her own child had been born. Moreover, the father and step-mother both tried to discipline the index person but would frequently relent in their efforts when the daughter protested and complained how unfair the parents were to her. The father requested counseling and therapy services through the local county Department of Human Services. Family therapy was voluntary. A female family therapist from West Iowa Family Service, Inc. provided counseling and therapy to the family for a period of one year. The therapist met regularly with the whole family, with the parents by themselves and with the index person individually

The father, the stepmother, the index person, and the baby son all participated in the interview. The interview took place at the dining room table of the family home in the late afternoon of August 12, 1999.

**5E: Vignette of Family # 05**

At the time of the interview Family # 05 consisted of twenty persons: Father, 49, Mother, 44, and eighteen biological children, ages 23, 22, 21, 19, 17, 16, 14, 13, 13, 12 (IP), 11, 9, 9, 7, 5, 4, 2, and an infant. The parents had been married once, to each other. Everyone resided in the same household located in a country home in western Iowa, in rural country with a population 8300. The family was white. The family reports they attend a local Catholic Church.

The father was employed as an independent contractor and roofer. His four oldest boys worked with him, doing mostly carpentry and roofing work in the local county. The family owned its own residence. The family considered itself working class.

Index person was a twelve-year-old boy who resided with his parents. He had been reported by teachers to be disruptive in the classroom and they wanted him to try an ADD medication, but the family was reluctant. In-home family therapy was offered by the county Department of Human services to the family to address ways to cope with the boy's attention deficit behavior. The continuing problems at school prompted the family to accept the therapy offer. Therapy was voluntary. A female therapist who worked for West Iowa Family Services, Inc. provided counseling and therapy to the family. Therapy usually consisted of Mother, the index person, and the therapist, with cameo appearances of the rest of the children in the home except the four oldest children who worked with their father. The family had therapy for approximately six months.

Mother, Father, the index person, twin sons and two other sons, the infant, and the researcher participated in the interview. The interview took place in the kitchen of the family home on the evening of August 21, 1999.

**5F: Vignette of Family # 06**

At the time of the interview, Family # 06 consisted of three persons: the mother, (41), and two biological children, a boy (18) and a girl (15). The mother was divorced from the biological father, had remarried, and had gotten divorced again. The biological father was emotionally removed from the children, so they saw him once or twice a year. The biological father had remarried and lived with the second wife and her two biological children from a previous marriage. The mother's second husband has been emotionally close to the index person during his teenage years and the index person had continued to work with the divorced stepfather on his farm. The two children lived with the mother and the family resided in a small town with a population of 800 located in western Iowa. All members of the family were white. The family reported they attended a local Lutheran church.

The mother worked for a manufacturing plant in a neighboring town. The index person had been working for a roofing company during the summer months to earn money to go to college. At the time of the interview the index person had graduated from high school and had been admitted to an Iowa community college in Council Bluffs, Iowa. The mother owned her own home. The family considered themselves a working class family.

The eighteen-year old son was the index person. The index person got into trouble with the law, broke into several buildings, stole some things, vandalized some school buses and was put on probation. The index person got off probation and the next night was caught for breaking and entering, and was placed again on probation. Part of the probation was mandatory family therapy. Family therapy was

not voluntary for this family. Family therapy was authorized by the Juvenile Court Officer of the local county to resolve why the index person continued to get into trouble with the law. A male therapist who worked for West Iowa Family Services, Inc. provided counseling and therapy to the family. The sister participated in family therapy periodically, but the focus of most of the therapy was on the relationship between the mother and the index person as well as individual therapy with the index person. The family had therapy for a year.

The mother and the index person participated in the interview. The interview took place in the kitchen of the family home on the morning of August 21, 1999.

**5G: Vignette of Family # 07**

At the time of the interview Family # 07 consisted of six persons: Father 43, Step Mother 33, biological son of the father, 16, three biological children of the mother, a son 11, another son 13, and a daughter 12. Both of the parents had been married once before and were divorced. The current marriage was the second for both. The father had another daughter, 15, who resided with the divorced spouse in a nearby town. The mother had another daughter, 16, who resided with the maternal grandmother in Utah. The family resided in a rural homestead near a small town with a population of 3000 located in western Iowa. All members of the household were white. No one in the family reported attending church.

The stepmother reported working in a local store as a clerk. The father reported working as a seasonal carpenter, mostly for himself. The index person indicated that he worked in temporary jobs mostly during the summer. The parents owned their own home. The family indicated that their income level was below the poverty level, but they had declined to take food stamps or other government assistance.

The index person was a sixteen-year-old child who resided sometimes with his father and sometimes with his mother. The boy indicated he usually chose to live with a particular depending on how tense it was at the other home. The boy's temper and violence in the homes prompted in-home family therapy to be offered by the local Department of Human Services to the family to resolve the child's violence and defiance. Placing the boy in Alpha House in Omaha had not resolved the problem, so the family accepted the offer of in-home family therapy. Family therapy



was voluntary. A male therapist who worked for West Iowa Family Services, Inc. provided counseling and therapy to the family. Everyone in the family participated in the therapy sessions. The family had therapy for a year.

Everyone in the family participated in the interview, Father, Mother, and four siblings. The interview took place in the living room of the family home on afternoon of August 11, 1999.

**Appendix 5h: Vignette of Family # 08**

At the time of the interview, Family # 08 consisted of four persons: Father, 45, Mother, 41, and two biological children, a daughter, 16, and a son, 14. The parents were married to each other and this was their only marriage. All the children lived with their biological parents. The family resided in a small town with a population of 9500 located in western Iowa. All members of the family were white. No one reported attending church.

The father was employed in a local bank as a professional. The mother was employed in a local manufacturing plant. The daughter worked part-time as a waitress in a local restaurant. The son indicated he worked in agricultural jobs during the summer. The family owned its own residence. The family considered themselves middle class.

Both children in the family had been index persons. The daughter, 15, was the index person for family therapy for six months. In the following six months the son, 12, was the index person for family therapy.

The daughter had been defiant, had come home drunk, drove without a license, and sneaked out at night. The boy subsequently had begun to associate with his sister's friends, to drink alcoholic beverages, to stay out all night, undermine parental demands, and had begun to smoke. After the parents had failed to curb the defiant daughter, they requested family therapy services through the local Department of Human services to address the conduct disorders. Family therapy was voluntary. A male therapist who worked for West Iowa Family Services, Inc.

provided counseling and therapy to the family. Everyone in the family participated in therapy. The family was in therapy for two periods of six months each.

The father, mother, and the son participated in the interview. The daughter was at work during the interview. The interview took place in the living room of the family home on the evening of October 5, 1999.

**5I: Vignette of Family # 09**

At the time of the interview, family #09 consisted of two persons, the mother, 45 and the biological daughter, 16. The biological son, 18, had been living with his mother but had moved out just before the time of the interview. The mother was divorced from the biological father of the two children. Both children had resided with the mother until the son moved away. Both children were completely estranged from the biological father, who lived with another woman and her children in the same town. The last time the daughter had attempted to visit her biological father, he had reported her to the police for trespassing. The family resided in a small town with a population of 400 located in western Iowa. All members of the family were white. The mother indicated that the family attended a local United Methodist church.

The mother was employed as a special education teacher in school district located in a neighboring town. The daughter worked a part-time job with a telephone-soliciting firm in a nearby town. The mother owned her own home. The family considered themselves as lower middle class.

The family had two index persons during the course of therapy. The son, at that time age 16, had been the index person for school problems. Subsequently the daughter, then aged 15, had become the index person for family therapy because the daughter defied her mother and was uncooperative with any family rules or expectations. In-home family therapy was offered by the Department of Human services to the family to address the defiance and lack of respect between parent and daughter and to resolve the lack of good academic performance on the son's

part. The family accepted therapy services voluntarily. A male therapist from West Iowa Family Services, Inc. provided therapy for the son and two female therapists also from West Iowa Family Services, Inc. provided therapy and counseling for the family while the daughter was the index person. Everyone in the family participated in therapy. The family received therapy for eighteen months.

The mother participated in the interview. The daughter was working during the time of the interview, and the son was no longer available to participate in the interview. The interview took place in the kitchen of the family home in the evening of October 6, 1999.

**5J: Vignette of Family # 10**

At the time of the interview Family # 10 consisted of six persons: father, 41, mother, 37, and four biological children, a son, 17, a daughter, 15, and daughter, 11, and a son, 6. The current marriage has been the only marriage for both parents. All four biological children lived with the family in their home in a small town with a population of 7400 located in western Iowa. All members of the family were white. The family did not attend church.

The father was employed as a technical support person providing computer services to banks. The mother did not work outside the home. At the time of the interview, the older son and the older daughter both worked in local fast food restaurants. The family owned their own home. The family considered themselves middle class.

The index person was fifteen years old at the time family therapy was offered to the family. The index person had refused to attend school and had secluded himself in his room for most of the day despite best family efforts to get him up. Eventually the son was charged with truancy, taken out of the home, placed on probation, and sent to the Boys and Girls Home in Sioux City, Iowa City. After five months in placement, the index person was returned home and required to attend school and receive In-home family therapy via the Department of Human Services to help the family resolve school attendance and social phobia behaviors. Family therapy was not voluntary. A male therapist who worked for West Iowa Family Services, Inc. provided counseling and therapy to the family. Every one who was at

home at the time participated in family therapy. The family had therapy for six months.

The father, mother, index person, 17, and the younger daughter, 11 participated in the interview. The interview took place in the dining room of the family home on the evening of October 15, 1999.

**APPENDIX 6:CHRONOLOGICAL ORDER OF THE INTERVIEWS**

<b>Title of the Interview Transcript</b>	<b>Date the Interview Occurred</b>
FAMILY # 01	August 9, 1999
FAMILY # 07	August 11, 1999
FAMILY # 04	August 12, 1999
FAMILY # 06	August 21, 1999
FAMILY # 05	August 23, 1999
FAMILY # 02	August 24, 1999
FAMILY # 03	August 25, 1999
FAMILY # 08	October 5, 1999
FAMILY # 09	October 6, 1999
FAMILY # 10	October 15, 1999



## **APPENDIX 7: INTERVIEW NOTES**

### **Family 1 Interview Notes**

Very affable

IP wanted to leave early,

IP wanted to quit therapy first

The little boys were left out mostly

Dad said he had decided when to quit, but actually mom decided

Fam had probs with older son too, but played those down

Fam has better view of IP as growing up, so they tend not to react very much to his problems, although he has some of the same probs they say

Open to my returning to check the findings

**Family 2 Interview Notes**

Mom protected from the strange therapist by her dad, but she resents his interference, she expects to run her own life

Mom very involved in the boyfriend, but played that relationship down

Mom maybe sees boyfriend relationship as a decision still to be made

Mom has taken the stalking by her husband in stride, once afraid, now doesn't even report it when she sees him, although still 'careful' about the house

Mom became an adult during therapy, sounds like; before she was dependent on a parent or her husband, now she is dependent on herself

Mom open to a call back about later findings.

**Family 3 Interview Notes**

They wanted me to come back and be their therapist; wanted to me come back next week if possible

Like talking about progress in therapy

Kid sees his dad is his hero

Dad likes the communication they gained

Problems are explained away by dad now, but wasn't always that way.

Dad's paramour much more pushy in her teaching, thinks she has a lot on the ball

Paramour is ½ Indian, some tribe in Nebraska, maybe Omaha.

Dad and son work at same restaurant

Paramour a little too forward for my taste; kid getting some of that same impression think. He and dad are buddies but with her there and her tension, I expect he is losing his buddy, she gets in the way

They would like a stop-back to check findings, drop-in probably.

**Family 4 Interview Notes**

Fam will accept a call-back for member check

Kid has grown up, parents say.

Parents say they have gotten consistent

Nice house, good job, strong middle class

Kids in Texas will probably come to live with dad when the boy gets to be 14.

All 3 say the kids in Texas like the structure and rules in the Iowa home

Parents really proud of the daughter, see her as soon to be an adult, only occasionally do they treat her as actually 16

Stepmom has good self-perception—how did they really get together I wonder. She looks up to him, so he must offer her something she hadn't found before, stability maybe, growing up with missionaries doesn't give much stability

Kid differentiates well, does chores without expressing too much resentment.

This family is actually sharing their lives with each other

Gave the therapist a lot of credit for progress.

**Family 5 Interview Notes**

This fam has 18 kids; hard to conceive

Mom didn't seem any more tired than most moms, but she did seem more passive than I would have expected, but I guess with 18 kids you can't expect her to be too proactive about stuff

Dad indicated he had been injured, but was now back at work, roofing mostly. Pretty old to be a roofer, some contracting

Dad took the lead in the interview; seemed to want to. Therapist told me yesterday not to expect him to even be there, so that was surprising

Mom wanted the therapist to provide the magical answer and the problem would all go away, so she is not sure outcome was positive

Therapist apparently normalized the problem for the family, plus the meds helped at school, but he doesn't take the medication at home, so they don't see the results of the meds. He's still the same; but they have changed

Mom recognized that an older son has ADHD too, but they didn't have as much problem or they didn't overreact, or the school wasn't as sensitive, or ADHD wasn't as noticed 10 years ago; not sure why this one got attention and that one did not

Dad sees each kid in terms of the work and help they can do with him or for him; he recognizes the kid is a kid, but he is 'waiting' for his help when he gets old enough.

Dad said when you double the kids, you half the work., i.e., if the kid has a friend along, together they will do half the work that the kid would do if he were by himself.

Others came in the kitchen, didn't introduce themselves and took care of business while our interview was going on; still the fam was cooperative

Fam prefers a call-back for member check, hard enough to schedule this meeting mom said.

### Family 6 Interview Notes

Mom presented herself as stronger than their story seemed to indicate.

Mom agreed she was part of the problem, yelling a lot

I wonder if the dissolution of her second marriage was occurring during the time of kid's greatest troubles with the law? That might account more for his devil-may-care attitude than rejection by the biological dad. Kid is still connected to stepdad, found a way to stay connected, maybe

Bio dad's rejection is mom's story: was it really reflected that much in kid's story. He told how dad disappointed him, but seemed like it was pretty much expected most of the time;

kid sister seemed missing from their stories.—I wonder why

Mom presented that story as the big adjustment, but how did they get 'adjusted'—not clear.

Individual therapy with the kid really helped him see things differently, now he is working, earning mucho money and going to college. Mom must really be proud

Mom not reactive to current shenanigans or recent cutups by kid, shows her increased understanding, determined not to get bent out of shape any more; let him learn his own lessons without her pointing them out.

I'll bet their relationship really gets enriched once he's away at school, they'll be able to talk and share a lot more; he'll be the head of the family along with her.

Kid must call home and indicate if he has been drinking – that's pretty unusual for any parent to set up as the rule, and for kids to follow. She must mean it.

Want a call back for member check.



**Family 7 Interview Notes**

Fam still needs therapy, but not really about the IP, about the marital rel

IP still a problem: progress was ephemeral, doing very well while the therapist was there, but disintegrating after the therapist left

Was the therapist maintaining a solution, or just maintaining the problem in a mild way

Fam said they wanted to continue therapy

Fam said the therapist was called later but refused to come out. Doesn't sound like the therapist I know.

Tried to find a way to get services again, but soon apparent they don't want anything to do with the social worker again, a new one or the old one. Didn't like the social work peering at their family

Mom is differentiating herself and this has the dad flustered.

A photo taken from a plane arrived that day of the house and its setting: mom interpreted the unexpected arrival as a sign that now they have a picture of 'how it was, so they can say goodbye; dad interpreted the unexpected arrival as signifying that they belong in that setting, so they shouldn't be leaving it.

Everyone seemed to like the interactions around the table

IP determined not to be 'fixed' by therapy, but mom has differentiated herself regarding him too, and he lives at her house only under duress.

If mom moves, her kids won't have a father, a father they have grown used to and on whom they depend for guidance and discipline. Hell could break loose when they get out west.

They are impoverished and have made the best of it, but mom's determination to differentiate based on moving back to be near her bio. family will probably increase their financial support. Will dad sit on his haunches and let them go without him?

The fam would take a visit back for member check, but it would end up being a therapy session; so phone back unless I have plenty of time. They probably would insist on a drop-in.

### **Family 8 Interview Notes**

Fam had two IP, so two service contracts; in one they got out with definite changes in the girl IP and in fam; in second IP they got extra services in day

treatment, the problems got worse, plus the boy had more 'bad' associates, so they were looking to drop out when the offer of renewal was made and they declined.

They initiated getting out really, not passive with the IP son, because they were looking at military school or some other options for a better solution

Mom felt son and dad needed a break from each other, and when they had that, really dad redefined his relationship with son; also son redefined his friendships once he got back home.

Upper middle class fam, he a bank veep, she a factory worker., with their jeep and other cars.

Dad said he learned to control his temper

Dad found ways to modify almost everything the interviewer suggested; felt pinned down I guess; too many pointed questions maybe at this point in the research.

Mom basically indicated that the break between dad and son is what worked, then when they got back together, they redefined their relationship. Sounds like her rel remained the same all the way through.

Son interested in being at the interview because he 'wants to be in the book you are

writing". Open to a revisit for member check.

**Family 9 Interview Notes**

I thought I was going to have to spend the night there—she really wanted therapy and ate up any praise I gave her

Mom needed praise therapy the whole time.

Mom kept referring to therapy, I thought she meant WIFS , but usually she meant therapy before WIFS or she meant the social worker whom she hates to much

Mom wants to bring a suit against the bad social worker, or embarrass her publicly in some way; mom was really hurt by the SW

It's going to be hard to differentiate the old therapist from the WIFS therapist, who generally got a good press

Mom had good outcome with son IP; poor outcome with daughter IP.

Mom says she used to be strong and take the initiative and made good decision, then she describes her life as abused daughter and abused wife and how overwhelmed she was by continuous abuse; wonder where she looks back for finding strength in her decisions

Mom said she was abused by her husband, how long I asked and I expected her to say a few years; she says 19.5. Wow, that's a long time.

Therapists needed to address the PTSD that mom had, no question, and it sounds like they didn't.

Boy, her story was long and involved.

Mom says the personal or individual therapist she had after all other therapist had gone home was the most helpful, they put on soothing music, discussed her

abuse and the strength to get out of abusive relationships, and then did a lot of role playing. That role playing came up numerous times after the taking was over. The role playing apparently helped overcome the old habits of succumbing to the emotional blackmail of her mom, husband, and now daughter

Mom says she's determined to let daughter suffer the natural consequences of her action, but then mom says she's found a counselor and tracker who will be the agent of control in daughter's life. Will he relieve mom again of having to hold daughter responsible

Mom was all over the place emotionally in her stories, must have been really hard on therapist to know where she's at at any given moment in therapeutic conversation.

### Family 10 Interview Notes

Mom and dad divided on stopping; dad wanted to continue therapy so therapist could maintain the solution; mom wanted therapy to end so family could stop wasting the therapist's time, because focus of therapy was too much on family, in mom's view, when it should have been on the IP.

IP has redefined the problem, but it took 8 months later to do it; he can pinpoint the actual day and time when the switch was cut on and the new life began.

The IP redefinition shows that mom was right, focus was too much on the family, not on the individual.

Dad says he learned to redefine his rel with his other kids, tat he had gotten so focused on the IP he had lost touch with his other kids, the therapist helped him see that and showed him how to get back in touch. Therapy outcome was positive for him because he got his focus off the IP, and more balanced for the rest of the fam. Mom thought therapy a waste of time

Mom didn't like games, checking out whether she was consistent, whether she was telling the truth

Dad says he experienced a "paradigm shift" when he learned to have more balance in his relationship with the other children in the family

Both parents agreed with each other that 95% of most kids who have problem the problems can be traced to the parents, so naturally the therapist would have to check out the family to see what they are doing wrong.

Mom indicated that she and dad will always be 'there' for IP, so didn't need therapy to emphasize that, but definitely mom doesn't see her role as being

proactive in any sense of the word with the IP when he quit school and refused to get a job. Mom let the kid fall into his bed, provided him with a TV for wrestling and a computer for surfing the net and left him alone to do like he wanted.

Mom doesn't seem to see her impact on the IP as much more active than the guy who sells tickets at the air port feels responsibility for the guy who is sleeping in the waiting room.

Mom sees 'being there' as her role, which never includes 'tough' love.

Give the ambiguity of their differences regarding therapy, prob. better to phone back for member check, but pretty sure they would accept a visit if dad is home; not sure if only mom is home.

## APPENDIX 8: MEMBER CHECKS

	Index person is a problem or has a problem at the beginning	Fam has a good/positive Outcome; Paradigm shift, redefine	W/ good outc., fam's view of term.: thpist starts term, fam adopts, safety, quits	W/good outc, IP is growing up, pars stronger, more confident	Fam has poor/ephemeral outcome – didn't go well, more probs
<b><u>Fam 1</u></b>	Conflict	Redefined	Yes, mutual	Yes/Yes	Crisis = No
<b><u>Fam 2</u></b>	Endangered, abuse	Yes	Thought about it, slowed down, quit	Yes/ Much stronger, independent	No
<b><u>Fam 3</u></b>	IP – yes	Definitely different, but still a teenager	Yes	Yes/Yes	No
<b><u>Fam 4</u></b>	IP- yes	Yes, we redefined our problems	Contract was near end, but we wanted to make sure before we stopped	She changed a lot; Yes, we were a lot more confident	No
<b><u>Fam 5</u></b>	IP at School	Yes	Medication/ not therapy	Not True/ terrible/ not sure	No



	W/poor outc, fam passive re: termination/ opts out for another intervention	W/poor outc IP still has prob., <u>is</u> prob.: pars resent attn to them	Fam's view of Thpist: good, but not influ the decision to quit	Fam's view of SW: some good, some bad, unsure how influ term.	Uniqueness es: IP wants to quit first; once out stay out
<b><u>Fam 1</u></b>	No	No	Real Good/ no influ	SW was fair	IP—Yes / Would do again
<b><u>Fam 2</u></b>	No	No	Very Good/ Therapist suggested stopping	Difficult communication; hard to talk to	IP – NA / Would do it again if crisis was bad enough
<b><u>Fam 3</u></b>	No	My older son (not IP) is like this	// It was a mutual decision	Felt good about SW, had had bad experiences in past but this SW was there to help	IP – No/ would try therapy again if needed to, it was a good decision
<b><u>Fam 4</u></b>	No	No	Good// Mutual decision	Felt good about SW; had bad exper in past; SW wants to help	IP – Never wanted in/ Would try again
<b><u>Fam 5</u></b>	Therapist did not help the IP	No// Experiment	Very Good//	Okay	IP—True / Would try again

	Index person is a problem or has a problem at the beginning	Fam has a good/positive Outcome; Paradigm shift, redefine	W/ good outc., fam's view of term.: thpist starts term, fam adopts, safety, quits	W/good outc, IP is growing up, pars stronger, more confident	Fam has poor/ephemeral outcome -- didn't go well, more probs
<b><u>Fam 6</u></b>	Yes	Yes	Yes	Yes/Yes	Have a crisis right now, but not at time we quit therapy
<b><u>Fam 7</u></b>	The family has sold their house and has moved to Utah;	did not find their new phone # in Utah.	-----	-----	-----
<b><u>Fam 8</u></b>	Boy IP Yes Girl IP Yes	Girl IP	Yes	Yes	Boy IP
<b><u>Fam 9</u></b>	Boy IP Yes Girl IP Yes	Boy IP	Stopped without us	Yes// Parents got stronger	Girl IP
<b><u>Fam 10</u></b>	Truancy	Experienced a change, but happened 2 months ago	No	Not true then, but true now	Yes

	W/poor outc, fam passive re termination/ opts out for another intervention	W/poor outc IP still has prob., is prob.,; pars resent attn to them	Fam's view of Thpist: good, but not influ the decision to quit	Fam's view of SW: some good, some bad, unsure how influ term.	Uniqueness es: IP wants to quit first; once out stay out
<b><u>Fam 6</u></b>	No	No	Yes, good, but not, did not influ decision	Supportive and helpful, but slow on uptake at times	Yes// Always an option
<b><u>Fam 7</u></b>	-----	-----	-----	-----	-----
<b><u>Fam 8</u></b>	Fam decided with Girl IP, with boy we needed another intervention	Yes//crisis	Yes//No	M: yes D: No	Girl IP –Yes Boy IP – Yes // would do it again
<b><u>Fam 9</u></b>	Passive, yes	Needed more focus on me, not in IP, not on us	Agreed wit 80% of what she said	Awful//ok	Boy IP—No Girl IP— Yes// You can always benefit
<b><u>Fam 10</u></b>	Yes	Yes	Excellent	SW okay in Iowa; in Minn—too slow	Yes// If had crisis, yes

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